The idea of clinical governance first appeared in the White Paper *The New NHS: Modern, Dependable*, where it was articulated as a framework for quality and accountability (DoH 1997). Others have identified it as creating an environment in which excellence in clinical care will flourish (Garretty et al 1999) and an initiative that ‘for the first time clearly merges responsibility for clinical and managerial leadership’ (Holt 1999). Dewar (2000) argues that while on one level clinical governance is easy to describe, at another it is much more complex. First, it is about making all NHS staff accountable through the now statutory duty of chief executives to ensure quality, and through more proactive professional regulation, and compliance with external quality inspection from the Commission for Health Improvement. Second, it emphasises the need for local ownership of quality improvement as well as organisational and professional development. He also suggests that the official definition of clinical governance has deliberately been left incomplete so that health professionals can ‘define their own systems of clinical governance in their own way’ (Dewar 2000).


The Royal College of Nursing (RCN) has actively engaged its membership in discussions about clinical governance, and used the feedback to inform and respond to policy. The first round of discussion groups took place in 1998, where participants highlighted the need to integrate existing systems, create the right culture, place the patient at the centre of all developments and make clinical governance meaningful to all staff (Harvey 1999, RCN 2000).

The second round of discussions in 1999 reinforced the need to change culture and make clinical governance meaningful to all staff. Although some shifts in culture were reported, there was a perception that barriers still existed between professionals and a lack of understanding about the roles, responsibilities and contributions of different professional groups. There was also a belief that organisations needed to do more to get the message of clinical governance across to frontline clinical staff. Barriers to the implementation of clinical governance were also highlighted. These included lack of time and funding for clinical governance and continuing professional development, and limited access for nurses to computers and library facilities (Jones 2001, RCN 2000, 2001).

**Summary**

This article outlines the findings from three RCN discussion groups, which aimed to gain an understanding of how nurses were responding to clinical governance and to what extent they were involved in its implementation. The article focuses mainly on the third round with clinical nursing staff, senior managers and clinical governance facilitators. Three key issues were reported by nurses taking part in all three rounds of discussion groups. First, there is the need to raise awareness among frontline clinical staff to ensure that clinical governance becomes recognised as an integral part of their clinical workload rather than being seen as an optional extra. The second issue is the need to change organisational culture to make it more receptive to clinical governance. Third is the requirement to establish greater levels of partnerships between clinicians and managers, patients and professionals, and professional groups. However, the authors caution that the organisational cultural change necessary for the successful implementation of clinical governance is not as straightforward as the literature appears to suggest, and argue that this remains a key challenge for organisational leaders, managers and clinical staff.

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**Key words**

- Clinical governance
- NHS
- Nursing

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this round, an attempt was made to obtain the views of clinical staff and managers. All the discussions were tape-recorded. Discussion groups were used because they bring a small group of individuals together to discuss an issue collectively. This method has been described by Blumer as ‘more valuable many times over than any representative sample. Such a group discussing collectively their sphere of life, and probing into it as they meet one another’s disagreements, will do more to lift the veils covering the sphere of life than any other device’ (Blumer 1969). Group discussions are also less time consuming and less expensive than one-to-one interviews.

Of the ten groups in the third round, the first author facilitated six groups alone, and three groups in partnership with the second author. One group was facilitated by the second author and the director of the RCN’s Quality Improvement Programme.

Data collection and analysis

Data were collected from ten groups of NHS staff working in all four countries of the UK. The groups were split evenly: five groups comprised staff nurses, senior staff nurses, ward sisters, charge nurses and clinical ward managers; and five comprised clinical governance facilitators and senior nurse managers. Participants represented secondary and primary care, and the total number of people involved was 84. Each transcript was read several times to get a sense of the things that seemed important to participants before data was categorised into themes. These themes were generated by paying particular attention to the aims of the third round of discussion groups. The aims were to:

- Find out nurses’ perceptions and interpretations of clinical governance.
- Explore the types of support required for clinical governance.
- Investigate the implementation issues that nurses identified.

Although culture was not addressed as a specific question, participants highlighted a range of cultural issues during the discussions, and for this reason it is described below as a separate theme.

Perceptions and interpretations

The perceptions of clinical governance held by clinical staff and managers converged in many cases, with all groups highlighting their commitment to the principles of clinical governance. Clinical governance was seen as an overarching framework for a whole range of existing activities, including quality improvement and risk management. It was seen as a mechanism for protecting and safeguarding patients and staff, through the use of core national standards and evidence-based guidelines.

There was an understanding that clinical governance had been established to improve public confidence in the NHS, but caution was expressed in terms of whether a centrally driven initiative was the best way to improve quality and accountability. Although the Chief Executive’s statutory duty for quality was recognised, what appeared to be less recognised was nurses’ individual responsibility for clinical governance. Participants felt that there needed to be a balance between top-down control and support and bottom-up commitment and ownership.

The discernible differences reported across the clinician and management groups appeared to be the level of the theory-practice gap. This was particularly clear from the experiences reported by clinical staff, where a number of practical difficulties were reported related to nursing skill-mix, nursing shortages and patient dependencies, which they felt were not always taken into account by those advocating clinical governance.

It was reported that organisations should do more to ensure that clinical staff understand and accept responsibility for clinical governance. In some cases, clinical governance was not always identified as a priority by clinical staff, because they were too busy ‘firefighting’, or trying to survive their shift without any adverse events or incidents. This perceived lack of prioritisation was linked to a belief that the resources necessary for its implementation were not forthcoming, as well as a belief that clinical governance was something that clinical staff could get involved in if or when they had the time.

In the clinical staff groups there was a perception that it was managers who did not understand clinical governance. It was suggested that management objectives appeared to be too closely aligned to financial governance, where management decisions, including those related to clinical risk, were made on financial rather than clinical grounds.

Culture

All participants were aware of the importance of creating a culture in which clinical governance could thrive. However, many described aspects of their organisations that differed markedly from the open, transparent learning culture seen as necessary to achieve clinical governance (DoH 1997, Harvey 1999).

Participants identified difficulties surrounding whistleblowing in a ‘blame’ culture. Clinical staff highlighted limited opportunities to report areas of concern, and in cases where they had done so, they reported receiving little or no support or feedback.

Clinical staff felt that a blame culture also had an impact on a patients’, users’, carers’ and relatives’ ability to raise concerns about healthcare services, often because patients or relatives did not want to ‘drop anybody in it’, or feared being labelled ‘difficult’.

In terms of clinical decision making, clinical governance was seen as a double-edged sword for medical and nursing staff. The accountability side
of clinical governance requires that healthcare professionals must be clear about the decisions they make. However, in some cases this can make it difficult for healthcare professionals to make decisions, because they are afraid of being held responsible for the consequences of those decisions. The way in which clinical governance was seen to inhibit clinical decision making was linked to working in an organisational culture still firmly rooted in fear and blame, where individuals might be held accountable for consequences arising from a systems failure.

Although managers felt that clinical governance had shifted medical thinking towards the importance of good documentation and incident reporting, there was an acknowledgement that the intense media spotlight might have reinforced a culture of secrecy in medicine. There was also a belief that giving the lead for clinical governance to medicine reinforced this culture of secrecy, resulting in doctors not changing the way they work. However, there was also an impression that cultural difficulties were less apparent in organisations where the lead for clinical governance was shared jointly between nursing and medicine.

There appeared to be little recognition of the need to create effective partnerships between clinicians and managers, although participants did recognise the importance of partnerships with patients and across professional groups. However, these kinds of partnerships were recognised as being difficult to achieve. Staff working in specialist areas such as A&E, oncology and intensive therapy units were confident that multiprofessional teamwork and collaboration were part of their routine work. However, staff working in areas such as acute general medicine reported feeling less confident about working collaboratively.

Participants reported a number of reasons why multiprofessional collaboration was difficult to achieve. First, clinical staff identified the hierarchy that still exists between nursing and medicine, where nursing is seen as subordinate. Second, there was a sense that specialist areas were better staffed, supported and resourced and had good channels of communication and a greater level of leadership.

Implementation

Participants identified a number of skills necessary for clinical governance, but there were differences of opinion about whether nurses had these skills. Participants felt that, although nurses have a range of skills, they might lack the confidence to apply them, or even fail to recognise or value them. In particular, nurses were seen as having strong observational and interpersonal skills, but, as reported earlier, there were concerns that they needed education and support to develop their leadership, audit and critical appraisal skills.

In terms of leadership skills there was a belief that nurses were not being equipped with these skills in their pre- or post-registration education. However, in some organisations, staff did have access to the RCN Clinical Leadership Programme, which was seen as helping to support nurses in progressing the clinical governance agenda. Nursing staff in some organisations also reported having access to the Leading Empowered Organisations (LEO) initiative, a leadership development programme aimed specifically at F and G grade nurses.

When asked to consider the kinds of clinical governance activities they were involved in, responses were variable. No one specific activity was identified by all groups, with the most common activities being acknowledged as clinical audit, risk assessment and risk management. Participants reported a number of factors that appeared to make implementing clinical governance easier. These included:

- The establishment of quarterly reviews that were seen as useful in ensuring that clinical issues were brought to the attention of the board.
- The use of a patient pathway as a way of illustrating different aspects of clinical governance to staff.
- Establishing the patient experience facilitator's
post to bring about the necessary partnerships with patients and users of the service.

Restructuring the organisation to ensure that all professional groups were given the opportunity to identify clinical audit and research priorities. An additional success factor in implementing clinical governance was commitment and investment in the idea. Implementation was enhanced in organisations where clinical governance was not seen as optional, but clearly identified as being an integral part of the organisation’s objectives. Participants also suggested that another way of promoting implementation was to ensure that clinical governance was made explicit in curriculum planning, so that nurses leave nurse education knowing what it is about, and what role they play.

A key challenge to nurses’ ability to influence the future direction of clinical governance was related to which groups held the greatest power and authority in the NHS. Managers believed that nurses had collective power, but were often unaware of this. However, some clinical staff believed that nurses had little or no power. Some of the problems facing nursing in terms of its sphere of influence included a belief that the profession suffered from a lack of leadership, and that it was not equally valued or respected by other healthcare professionals. There was also some suggestion that nurses themselves did not value nursing.

Clinical staff believed that nursing was fragmented with nurses working in ‘little boxes’, meaning their area of practice, and failing to recognise their potential strength. There was a belief that if nurses could come together and speak with one voice, then the profession could have a much wider influence on the direction of clinical governance and the wider healthcare agenda.

Summary

Participants understood and were committed to the principles of clinical governance, even though they held a number of different perspectives and reservations. In terms of changing organisational culture, there was a sense that clinical staff felt unable to voice concerns about poor or negligent practice, primarily because some of the organisations in which they worked were still locked into a practice, primarily because some of the organisations where clinical governance was not seen as part of the organisation’s objectives. Participants also suggested that another way of promoting implementation was to ensure that clinical governance was made explicit in curriculum planning, so that nurses leave nurse education knowing what it is about, and what role they play.

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Conclusion

Following the second year of clinical governance, nurses are committed to its principles of quality and accountability. However, the way in which clinical governance is being successfully implemented across organisations remains variable. Comparing the third round of discussion groups with the first two, nurses continue to report the same concerns.

First, the apparent inability of many organisations to implement clinical governance means that it continues to be seen as an optional activity. Until all staff at all levels understand, participate in and are encouraged and supported to get involved in clinical governance activities, it is highly unlikely that the systemic change the government (and by definition the public) is asking for will happen. Organisations need to ensure that nurses are provided with the necessary resources for personal development and education to encourage clinical ownership and commitment to clinical governance. They also need to be consistent in communicating a positive message that clinical governance is a developmental, learning process, rather than a coercive force.


Whereas the importance of changing culture was recognised, it is also important to recognise that organisational culture is not simply a homogeneous entity. In healthcare organisations, as in other organisations, there might be a set of interrelated and potentially conflicting cultures, each with its own set of sub-cultures. Once the heterogeneity of organisational culture is recognised, it is also important

REFERENCES


to recognise that changing a range of organisational cultures will require a range of cultural change strategies (Allaire and Firszt 1984, Barley and Gash 1988, Bate 1984, Gagliardi 1986; Meyerson and Martin 1987; Rose 1988, Wilkins and Gibb Dyer 1988). There is a real dilemma for those advocating cultural change, not least because we need to know what it is we are hoping to change, as well whether such a change needs to be evolutionary or revolutionary (Bate 1994, Davies et al 2000, Gagliardi 1986, Hackett et al 1999, Meyerson and Martin 1987).

Finally, the reported gaps in effective teamwork, collaboration and partnerships are part of the cultural dimension of clinical governance. However, while the notions of teamwork, partnership, collaboration, empowerment, user participation and user involvement are used extensively in the clinical governance literature, there needs to be further exploration of these concepts and greater understanding of what achieving involvement and participation, especially from healthcare users, entails (Collins 1994, Collins 1997, Coombs 1998, Firth-Cozens 2001, Freeman et al 2000, Hickey and Kipping 1998, Pitkeathly 1999, Rowe 1996). As clinical governance evolves into its third year, it appears that some organisations are also evolving in the right direction. However, what is also apparent is that a number of healthcare organisations appear to have made little headway in bringing about the desired cultural change necessary for the systematic implementation of clinical governance across the NHS. The level of organisational cultural change required continues to be a major challenge for organisational leaders, managers and clinical staff.

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