Clinical Governance
Organisational Culture
Leadership

Practitioner Thesis
Master Professional Practice

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Contents

Attestation

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of an institution of higher learning.

Executive Summary

In this practitioner thesis, I describe the dual development of a practitioner project within my practice framework as a registered nurse with experience in the health and disability sector.

The focus of my research is to discover empirical data about the subject of clinical governance, organisational culture and leadership. My aim is to describe how senior managers and leaders, including governance, describe their views and insights to offer these findings within a context that enables me to consider new ways of approaching this complex topic.

My professional aim in completing the MPP is to develop deeper knowledge as a practitioner.

My research project utilised a phenomenological methodology and an interpretivist framework of qualitative research (Cody and Mitchell 1996). Costley, Elliott and Gibbs' framework for work-based research guided part of the process. (Costley, Elliott, and Gibbs 2010) My Academic Mentor provided supervision of the project. Data collection methods involved active discovery utilising interviews and a focus group. Literature search assisted with supporting and commenting on the research discoveries.

Otago Polytechnic Ethics Committee reviewed and approved the ethics application.

My research question:

> **How do staff describe their understanding of clinical governance and is there a relationship between clinical governance organisational culture and leadership?**

Key learnings confirm that clinical governance is a complex concept. Understood in content by senior staff, but less so by clinicians. Leadership of clinical governance is highly dependent upon organisational culture. Staff readiness to engage relies upon relationships with leaders and is related to their level of trust and psychological safety in their work environment. My research findings propose that:

- Clinical governance should not be treated as homogenous group subject; it is made up of many components that create the whole.
- Clinical governance committees are seminal in the relationship between floor to board communication and foster professional respect and collegiality and inform, governance decisions.
- Clinicians would benefit from clinical governance education.
- Staff engagement should not be confused with staff satisfaction.
- Organisations need to foster good engagement with staff.
- Leadership is based on respect, trust, valuing others, being fair and just.
- Staff need to feel psychologically safe to perform optimally and engage fully in their work role.

- Boards could improve function and relationship by considering *how* they engage in clinical governance with a view to understanding relational needs of participants.
- Staff culture surveys are not an indicator of organisational health. Willingness to participate, do a good day's work and engage is more indicative of the health of the organisation.
- Frameworks are useful to guide process but are not the driver of clinical governance.
- Taking time to understand why staff engage or disengage can assist with understanding what needs attention within the organisational culture.
- Smaller organisations have challenges that are different in nature to larger organisations especially related to power and authority.
- Strategy and definitions are not front of mind for staff in day-to-day work.

My initial plan to define a toolkit to assist organisations in introducing clinical governance has changed direction somewhat throughout my project. Indeed, I have discovered there are many enablers of clinical governance in existence; multiple sources of frameworks, processes each supported by research and literature. It is a well-studied topic. The beauty for me in completing this project relates to unexpected findings and the richness that has added to my growth as a practitioner. My hope is that by sharing my view of the world as I now see it, will encourage my peers to also take a second look and see what is happening in their organisations as opposed to what they choose to see.

Chapter 1: Introduction

Hutia te rito o te harakehe	If you pluck the heart from the flax bush
Kei hea te korimako e ko?	From where will the bellbird sing?
Ki mai koe ki ahau;	You ask of me:
He ahu te mea Nui o te ao?	What is the most important thing in this World?
Maku e ki atu,	In reply, I tell you
He tangata he tangata he tangata.	It is people, people, people.

In this practitioner thesis, I describe the dual development of a practitioner project within my practice framework, registered nurse , manager and leader, with experience in health and disability. In this first chapter, I discuss my framework of practice, the changes in my practice associated with developing the desired change and potential impact of my thesis.

The focus of my research is to discover empirical data about the subject of clinical governance, organisational culture and leadership. My aim is to describe how senior managers and leaders, including governance, describe their views and insights in this topic and to offer these findings within a context that may enable organisations to appreciate new ways of approaching this.

My professional aim in completing the MPP is to develop deeper knowledge as a practitioner with expertise in clinical governance, organisational culture and leadership.

Motivation for this work, includes understanding the formative experiences and skills acquired during my career.

My practice framework as a senior manager and professional leader developed rapidly following my early career as a registered nurse, which began in England in 1984. I trained in the modular apprentice-training program, which is significantly different from today's degree based tertiary qualification. In 1986, I immigrated to New Zealand. My early years of practice, in both countries, educated me in various ways; I was inquisitive, needed to excel, and enjoyed learning.

The platform from which my practice framework emerges began rather unexpectedly, and cemented my values and professional perspectives. I happened upon New Zealand at a time of transformation in health, this being in 1987 when the 'Unfortunate Experiment' at the National Women's Hospital in Auckland took the country by storm. The Cartwright Inquiry, (Ministry of Health 1988) resulted in far reaching consequences for health professionals and patients and their whānau. Nursing, as a profession, was not unscathed; indeed, the criticisms of nurses, their silence, complacency and complicity compelled those of us, even if junior leaders, to act and take the lead on establishing processes and mechanisms that improved the experience to which women were exposed. The exposure

of the internal professional struggles identified a very unhealthy organisational culture. Transformational leadership clearly had a place within the future of National Women's Hospital.

Moving in 1997 to a tertiary health organisation, initially as a manager and then a professional leader offered a different challenge as past health reforms had supported the disestablishment of professional leadership executive roles in healthcare institutions, instead focusing on generic, performance-based managers. The patient became less of a focus as containment of spend became the priority. Systems for quality audit and assessment of errors and mistakes, and improvement opportunities were almost non-existent. Applying my prior experience, and having become adept working with a difficult organisational culture, I had acquired enough knowledge and appreciation of the need for systematic assessment and introduction of quality initiatives, and applied my skills to lead a large workforce. More so, the external drivers beginning to be implemented subsequent to Cartwright, impacted upon all professional practice disciplines. Serendipitously, this enabled me to work at an organisational level to establish professional leadership and improve the focus on quality patient outcomes. In particular, understanding why error occurred became more important as the external agencies such as health and disability commissioner investigations supported internal desires to work effectively in this crucial area of healthcare. On reflection, significant improvement in systems and safety occurred over those years; however, there is no panacea for total removal of error in any human driven service and my motivation, among many competing challenges, was to ensure that staff were the recipients of humane and supportive processes when investigations occurred, and that families and patients felt respected.

My work within the disability sector, sensory loss, has completed my 'holistic' experience of leading and managing in a complex sector. In some ways, disability is more politically complex than acute or primary care; it is also the poorer of the two and struggles for adequate compensation compared to demands within the acute sector of our rationed healthcare system. Decisions made by purchaser's impact profoundly on the recipients; those living with enduring disability face daily barriers that for most of us would not be a concern. Without effective advocacy and lobbying, many individuals living with a disability would experience real difficulties accessing support in communities including employment, being safe in their environment and access to healthcare services. Political savviness, being tenacious, and pushing hard for adequate funding became my common practice.

Clinical Governance - what is it? Simply put, it is often described as an 'umbrella' term to describe a plethora of activities and systems working together to assist with quality and safety in the delivery of healthcare. Introduced in the UK in the 1980s the term has been part of systematic change in the NHS. Drivers of this quality initiative include major harm events such as the Bristol Cardiac Babies (Alaszewski 2002) and the Shipman Inquiry (Smith and Shipman Inquiry (Great Britain) 2003). Closer to home, New Zealand experienced Cartwright (Ministry of Health 1988), and the Gisborne Pathology inquiry (Richardson 2001).

Defining clinical governance is difficult. The most ubiquitously quoted, including within New Zealand, is the NHS definition:

> "Clinical governance is a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of

> care by creating an environment in which excellence in clinical care will flourish." (Scally and Donaldson 1998).

The New Zealand Health Safety and Quality Commission also states in its guidance for health and disability providers framework document:

> "Assure the governing body of the organisation that the health and disability services they provide are safe and of a high quality." (Quality and Commission New Zealand 2017b)

The goal of clinical governance as a system is reduction in error and harm to patients. Clinical governance information is prolific; frameworks and quality improvement tools introduced in the hope of improved ways of working towards a safety culture. Frameworks and literature are core to successful engagement in this complex concept. My practitioner experience has exposed the challenge of the 'how' and 'what' leadership must do to take staff along on the clinical governance journey.

My practitioner focus recognises my past learnings and the value they bring. I consider the deeper knowledge I have discovered as part of my research to help me achieve an advanced practitioner relationship. Understanding the more subtle influences that matter to both individuals and organisations may assist some organisations and individuals to achieve success in their state of readiness to begin this journey.

My learning agreement outcomes begin with an overarching question:

> **How do staff describe their understanding of clinical governance and is there a relationship between clinical governance, organisational culture and leadership?**

I aimed to discover the following:

- The tacit links between leadership and effective clinical governance.
- The impact of organisational culture on a sustainable clinical governance model.
- Organisational perspectives on benefits of clinical governance and what matters, or doesn't matter, to practitioners in their day to day activities.
- Who leads a clinical governance model; who should participate to increase effectiveness or does a lead develop organically in organisations.

My research project engaged three health provider organisations. The research methodology utilised a phenomenological methodology and an interpretivist framework of qualitative research. So what , in a nutshell, did I find out?

Good governance recognises that the people create the culture in which clinical governance may or may not flourish. My research placed clinical governance as part of a continuum of good governance. Everyone knew something about clinical governance. Roles that hold explicit responsibility for leading clinical governance leadership describe it fluently; whilst others that contribute, have had to learn about it by watching and participating.

Mistakes and errors happen, and when they occur my findings show staff want to feel supported. Having a just and fair culture based on demonstrated leadership values matters to leaders and clinicians. The link between culture and errors should not be ignored or brushed over as it is felt the two nearly always interact. Relationships, trusting each other and feeling valued, develop from consistent, sincere authentic engagement. Values and trusting each other, supporting staff when things do not go so well should be nurtured. Speaking up, being just, and challenging the status quo should be encouraged as well as establishing strong, authentic, consistent engagement with staff. Engagement with staff must be sincere and not a one-off process.

The clinical governance committee emerged as an important forum. Strong direction and purpose could improve relevance of clinical governance committee functions and overall satisfaction of participants. Feedback matters to individuals in that it invites further engagement and affirms the role of the committee having relevance to governance decisions. Recognition of the '*collective professional voice*' as heard via the committee implies respect and recognition of the '*weight*' of clinical expertise and is crucial in effecting good clinical governance.

Meaningful language in everyday work is important to staff. Frameworks need to suit the organisation and be able to be understood by all levels of staff. Measure what matters and work with governance to understand the data and implications.

Organisational culture at its best is when people feel okay to come to work and do a good job – it's what the place feels like when you walk in. Measures of culture need follow-up with conversation and relationships focused on solutions.

In this chapter I have introduced the background and development of my practitioner project, as an executive professional leader and practitioner in health and disability; I have briefly described my findings of the practitioner project that influence my future framework of practice as a practitioner in clinical governance, organisational culture and leadership. My research findings indicate that for successful clinical governance, organisations should attend to the softer 'culture' needs of their organisation such as relationships and values based engagement before applying frameworks, or staff may feel disengaged from the process and purpose.

Chapter 2: Literature

My previous chapter identifies the themes that emerged in my research. The themes are meaning of clinical governance, communication and engagement, the role values-based leadership played in relation to the organisational culture, and the significance of the clinical governance committee.

Literature reviews often begin with definitions. There is not one specific definition in use for clinical governance; however, the widely quoted definition:

> "Clinical governance is a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Scally and Donaldson 1998)

New Zealand defines clinical governance as an 'evolution,' and a 'composite mix' of activities and relationships that link governance, management and practice including four key principles that put the patient at the centre of care, promote an open and transparent culture, staff actively engage, and the focus is on continuous quality improvement. (Quality and Commission New Zealand 2017b)

No formal definition for New Zealand has been adopted by policy makers, possibly because the components of clinical governance are evolving. The umbrella nature of clinical governance includes aspects of leadership, ownership, financial ownership and patient centered practice. (Flynn, Burgess, and Crowley 2015b).

Gauld further adds to understanding by describing clinical governance as 'an indistinct concept' creating 'multiple meanings to different players' thus somewhat contrasting the government policy expectation that clinical governance is central to patient outcomes. He goes on to comment that the lack of a common working definition has resulted in creating a challenge when communicating what clinical governance is and how it makes sense to the workforce. (Gauld 2014)

Som approaches the definition of clinical governance by considering it an integrated approach to care encompassing the overall patient experience and suggests that it is widely accepted that clinical governance is "*designed to integrate, consolidate and codify fragmented approaches to quality improvement*." He proposes that there is a need for understanding the integration process and teases out the organisational dimension of clinical governance to allow an appreciation of the impact on organisational structures, processes and function. (Vanu Som 2004)

Brennan offer definitions of the umbrella term:

> "'*Clinical governance*", comprising, "*a mixture of activities relating to governance, management and practice which is confusing for those expected to execute those roles*."

Furthermore:

"*What was new about clinical governance, compared with previous quality initiatives, is the focus on corporate accountability for clinical quality, leadership, organisational culture and organisational quality strategies.*" (Brennan and Flynn 2013a)

Despite the ambiguity that exists in defining clinical governance within New Zealand, the overt link with governance is based upon government policy as stated:

"*The DHB board provides governance and oversight of all quality improvement activities."* (Quality and Commission New Zealand 2017b)

This is further supported by Scally:

"*If clinical governance is to be successful it must be underpinned by the same strengths as corporate governance: it must be rigorous in its application, organisation wide in its emphasis, accountable in its delivery, developmental in its thrust, and positive in its connotations*." (Scally and Donaldson 1998).

Governance or corporate governance definitions also vary; as a generalisation though most describe a prescriptive approach to the picture of how governance should work.

OECD describes governance as:

"*The system by which business corporations are directed and controlled. The corporate governance structure specifies the distribution of rights and responsibilities among different participants in the corporation, such as, the board, managers, shareholders and other stakeholders, and spells out the rules and procedures for making decisions on corporate affairs. By doing this, it also provides the structure through which the company objectives are set and the means of attaining those objectives and monitoring performance".* ("OECD Principles of Corporate Governance Meeting of the OECD Council at Ministerial Level" 1999)

On a global scale WHO speak of 'stewardship':

"*The operational framework relates six functions of stewardship with national contexts, values and ultimate goals pursued by health systems: to define the vision for health and strategy to achieve better health; to exert influence across all sectors for better health; to govern the health system in a way that is consistent with prevailing values; to ensure that system design is aligned with health system goals; to better leverage available legal and regulatory instruments; and to compile, disseminate and apply intelligence*."
(Veillard et al. 2011)

Corporate governance definition such as defined by Shortell and Kaluzny (1994):

> "*The function which holds management and the organisation accountable for its actions and which provides management with overall strategic direction in guiding the organisations activities*." (Burns et al. 2012)

Carver' describes the relationship between board and management as being based on 'means' and 'ends'. Carver's policy governance model proposes that governance has two components: 'means', being the management of activities which in turn fulfil the 'ends'. The outcomes required by the board. The paper highlights the need for governance to not interfere in management, but to secure the necessary advice and information to enable them to make good governance decisions. This segues to the role of advice to the board and importance of governance not interfering, and therefore confusing the two distinct activities. This may be worthy of more consideration in relation to what skills are required by boards to ensure that the right questions are asked of others, answers they receive are understood and that they ensure adequate information to assist the board decisions. (Michigan College n.d.)

In contrast to Carver's model, Chait and Taylor in Governance as Leadership argue that governance as leadership provides a different way in which boards can work with fulfilling their responsibilities. Their model introduces the value of a 'generative approach' to add a different dimension to board function by inviting opportunities to gain perspective and insight into governance decisions, thus improving board governance understanding and appreciation of the what, why, how and consequences of decisions. Focused initially on the not for profit sector, but applicable in the government and corporate sector, this model of governance compliments the role of clinical governance as part of the continuum of governance somewhat more positively than the purely strategic (foresight) and fiduciary (oversight) functions of boards by adding the generative (insight) component. (Taylor, Ryan, and Chait 2013)

Trower recognises and values the opportunities to gain insights and improvement through opening up discussion and debate, and therefore understanding of the items that are not always represented by expertise around the table. Activating this in the context of clinical governance implies that clinicians would need to be invited for specific discussion to the board table to inform such discussions. Trower talks of '*Diligence through productive engagement*" and suggests boards are wise to benefit from using the technical expertise available - inputs that only certain individuals can offer. She suggests that boards are more productive when engaged in meaningful work and should harness the expertise available to make wiser, better decisions. Clinical governance as a concept exists for this very purpose; the desire to engage relies solely on board intention to seek expert contribution, collegial conversation and thus utilise the wisdom available. She also suggests that the conversations from using experts illicit more questions, more discourse and therefore a sounder understanding of consequences of decisions. (Taylor, Ryan, and Chait 2013) p139.

Trowers, 'The Leadership as Governance Model' suggests that assessing board competencies can enhance opportunities for improved governance.

This tool, the Board Self-Assessment Questionnaire (BSAQ) conceived of competencies in six dimensions as follows:

1. Contextual dimension. The board understands and takes into account the culture, values and norms of the organisation it governs [12 items].
2. Educational dimension. The board takes the necessary steps to ensure that all board members are well-informed about the organisation and the professions working there as well as the board's own roles, responsibilities and performance [12 items].
3. Interpersonal dimension. The board nurtures the development of board members as a group, attends to the board's collective welfare, and fosters a sense of cohesiveness [11 items].
4. Analytical dimension. The board recognises complexities and subtleties in the issues it faces and draws upon multiple perspectives to dissect complex problems and to synthesize appropriate responses [10 items].
5. Political dimension. The board accepts as one of its primary responsibilities the need to develop and maintain healthy relationships among key stakeholders [8 items].
6. Strategic dimension. The board helps envision and shape institutional direction and helps ensure a strategic approach to the organisation's future [12 items].

(Trower 2013)

Braithwaite says that finding the confluence point of governance and clinical governance offer components and responsibilities is the key to good governance. Corporate governance is concerned with running the business successfully, and that there are many definitions, each concerned with the oversight of fiscal responsibilities, direction, accountability control and decision-making. Paralleling the corporate responsibilities, clinical governance requires accountability, effective results, effective use of resources and acceptable results also. The key difference is the focus of clinical governance, being the ward or unit and that 'bridging' that divide is the challenge for board and executives. Components of a clinical governance approach include four headings: *Advocating for positive attitudes and values about patient safety and quality; Planning and organising governance structures for patient safety and quality; Organising and using data and evidence; Sponsoring a patient focus.* This model emphasises that governance begins at the highest level and that it is a leadership responsibility to set organisational agendas for corporate and clinical governance. First to emerge is leadership values, with accountability being at the 'heart' of clinical governance. This value needs to be demonstrated at each level of the organisation. Quality improvement, continuous education and a focus on ethical decision making – who gets what, under what circumstances and by what criteria - the fundamental basis of much of the conversation of clinical governance decisions. Managing risk, performance, credentialing and managing critical incidents and complaints places the welfare of the patient at the forefront. Supporting use of

data effectively feeds the decision making process for clinical governance and governance based on evidence and fact. The complexities of working between the two domains are key to successful clinical governance. (Braithwaite et al. 2008)

Conway reflects the importance of 'getting boards on board' by making quality a top priority. By focusing on specific targets such as reducing harm, hearing stories, creating measures that matter and creating a respectful and accountable cultural that invites a learning approach, require clinical expertise to achieve. Engaging clinicians in such a culture is inclusive, relevant and respectful. (Conway 2008)

Clinical governance as a concept developed in 1990s following significant public enquiries such as Cartwright and the Gisborne Cervical Smear pathologist failures (Richardson 2001; Ministry of Health 1988). Concurrently public inquiries were emerging in the UK that forced changes in the NHS process, systems and ways of working, Bristol cardiac babies (http://www.bristol-inquiry.org.uk/), Shipman Inquiry (Knox 2002). The outcome of the inquiries was to assure the public of the intention to protect the patient from harm or error, improve systems and improve health professional accountability. Impact on health professionals and practice within organisations was profound. Skegg in his introduction to his post Cartwright collection of essays writes:

> "The Cervical Cancer Inquiry and its report (known as the Cartwright Report) were momentous events in the recent history of New Zealand. Critical issues were at stake: matters of life and death; the life's work of leaders within the medical profession; professional reputations; public trust in the profession, and its own sense of self-worth." (Skegg 2009)

The Health and Disability Commissioners Act offered protection of patient rights and imposed obligations upon organisations. (Ministry of Health 1994)

Legislation forcing practitioners and organisations to become accountable was introduced; Health Practitioners Competence Assurance Act 2003 enabling statutory investigation of a breach of standards by health professionals.(Ministry of health 2003)

Skegg noted that:

> "The introduction of such legislation was a game changer, and it is likely that without such change, little if any progress for patient's rights and safety would have been able to be achieved post inquiries." (Skegg 2009)

The ‘Quality Jigsaw’ demonstrates some of the external drivers of quality introduced to organisations.

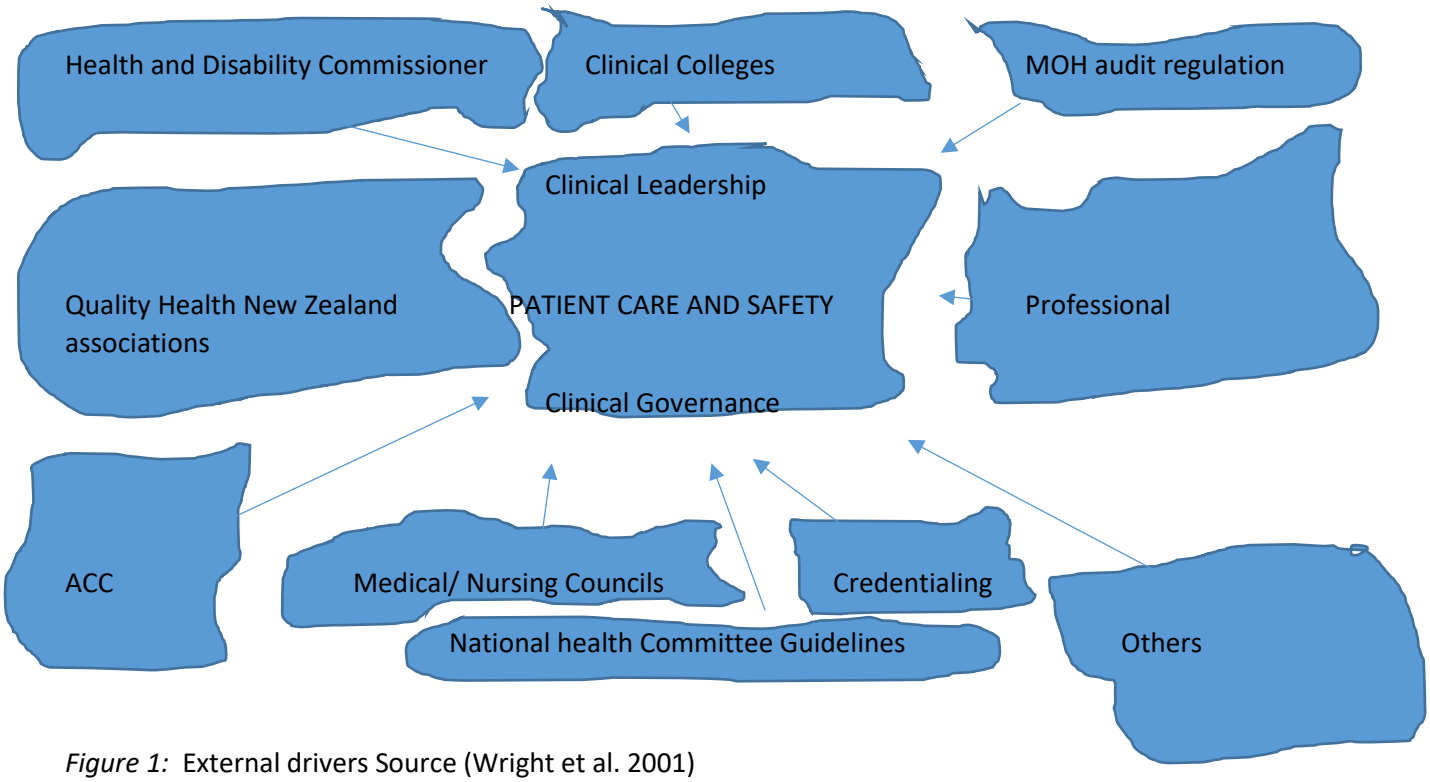


Figure 1: External drivers Source (Wright et al. 2001)

In 2014 Gauld, interviewed clinicians and leaders from 19 of the 20 District Health Boards within New Zealand. He found clinical governance was not clearly defined; it was an ‘*indistinct concept*’; it required ‘*strong clinician and management led partnership’*, a ‘*good strategy*’, and that ‘*creation of the forum*’ for fostering such partnership warrants attention. (Gauld 2014)

Clinical governance guidance in the form of frameworks, for government and non- government health and disability organisations within New Zealand ‘Clinical Governance: guidelines for health and disability providers’ emerged in 2017. Developed by the New Zealand Health Quality and Safety Commission, it introduces clinical governance as:

> “*Doing the right thing, at the right time, by the right person, with the application of the best evidence to a patient’s problem, in the way the patient wishes, by an appropriately trained and resourced individual or team, working within an organisation that is accountable for the actions of its staff, values its staff (appraises and develops them), minimises risk, and learns from good practice and indeed mistakes*.”

Implementation of the framework is based on 'building blocks' which focus on:

> "*Consumer engagement and participation: making decisions about their own care and taking part in the design, delivery and evaluation of the services they use, clinical effectiveness: the application of knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients, a commitment to working on quality improvement and patient safety, an engaged, effective workforce*." (Quality and Commission New Zealand 2017b)

It offers a simple assurance to readers that:

> "*Put simply, clinical governance is a collaborative venture between clinicians, managers and consumers that aims to 'create a culture where quality and safety is everybody's primary goal."* (Brennan and Flynn 2013b).

The framework notes its underpinning values as consumer wellbeing and safety. Described as larger in scope than any single quality improvement initiative, it requires clinicians and managers to be engaged in both the clinical and management structure of their organisation. To make further sense of the concept for staff it quotes:

> "*People struggle with the phrase clinical governance, but really it's about having a framework in place throughout the organisation, that supports you to be explicit about the standard of care delivered, about how you protect patients from harm, about how you listen to patients, and about how you plan and measure improvement*."

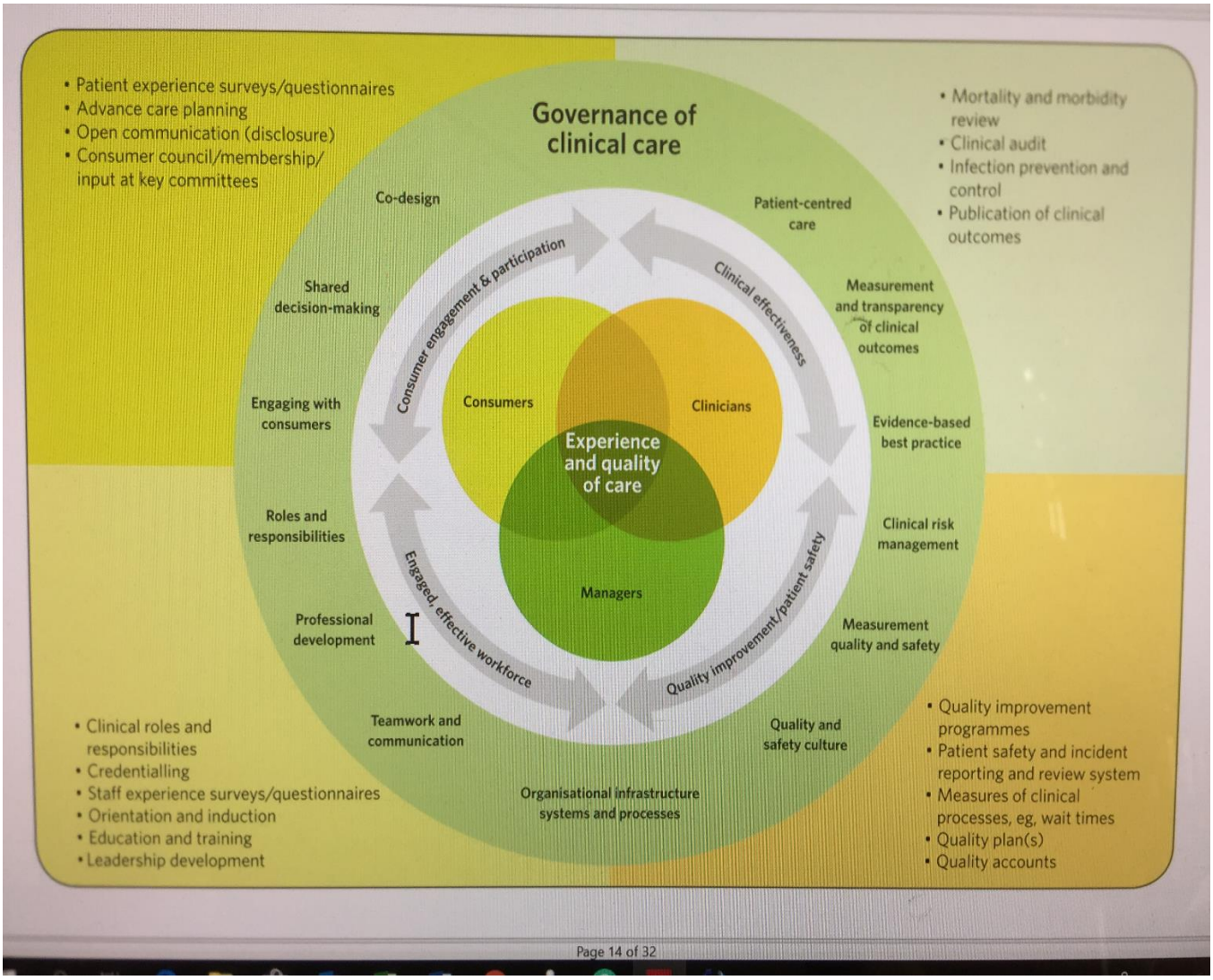
Acknowledging that responsibilities and accountabilities apply even in smaller organisations, the framework also states that:

> "*Clinical governance needs to be meaningful and accessible to frontline clinical staff as it is to managers and senior leaders*."

Though the consumer group may be smaller and less complex in smaller organisations, it emphasises that:

> "*The focus in not on the size but the shared responsibility and accountability for the culture of engagement in patient safety and continued quality improvement.*" (Flynn, Burgess, and Crowley 2015a; Quality and Commission New Zealand 2017a)

The diagram is offered as explanation of the components of clinical governance.



Source: (Quality and Commission New Zealand 2017a)

Values, organisational culture and leadership emerge in most references and frameworks of clinical governance. The complexity of clinical governance, as demonstrated by the diagram above, is reliant on leadership to engage staff in the topic. The organisational values and way an organisation behaves is considered a central factor in whether staff uphold values and participate in improvement opportunities. Behaving in a fair and just culture, leadership WalkRounds to gain insights, and systematic training in effective communication and teamwork are considered crucial if safety is to be improved (A. S. Frankel, Leonard, and Denham 2006). Functioning well requires multiple systems to

connect, and someone to lead this process. Organisation with less healthy internal cultures (E. Schein 2010), or those with corporate governance process focused on strategic and fiduciary that fails to recognise the value of their social capital to influence generative clinical leadership may struggle. Effective collaboration between board and management and diligence through productive engagement enables leaders to assist with the learning process of boards and staff - essentially the 'sense making' part of the *governance* role requires good judgement about what matters to the organisation and understanding the consequences of decisions. (Taylor, Ryan, and Chait 2013).

Schein states:

> "*Truth cannot be found without debate and one must subject their views to the crucible of debate among strong and intelligent individuals to progress a decision*." (E. Schein 2010)

The way organisations respond to error reflects their values and culture if clinical governance is to '*flourish*'. (Scally and Donaldson 1998)

Also, these need to be '*systematically and consistently implemented in an integrated fashion'*. Accountability as a value espoused by leaders emerges as key to organisational learning culture; understanding accountability, being held to account, requires a willingness to be comfortable to expose individual weakness and create an environment in which staff feel safe. Comfort with and in such an environment improves relationships and safety, and maintains and promotes the value of accountability as well as fostering respect for each other. (A. S. Frankel, Leonard, and Denham 2006)

No blame culture is relevant to clinical governance in the context of learning from error: Professor Ron Paterson, past Health and Disability Commissioner presents an insightful review of why organisational learning is so important in health. Paterson's ability to describe the 'Learning or Lynching' dichotomy is enlightening, his quest for natural justice and impartiality when investigating sentinel events or errors matters to those who have the misfortune to be involved in such instances. (Paterson 2008)

To understand organisational culture and the role leadership plays in leading and creating the desired culture, Schein offers that to begin to understand organisational culture and therefore achieve integration clearly requires some knowledge of the influencers and creators of the artifact that we call culture.

Artifacts that make up the culture consist of three levels within organisations:

- Surface artifacts: What we see, hear, feel; the sensory experience. Visible artifacts such as language, technology, products, myths, stories. How we present to others by way of greeting or recognition.
- Espoused values: what we say we will do - over time these values embed in the culture if a leader is successful. In promoting the desired value successfully, over time a shared value becomes a shared assumption of the group; these are especially strong in organisations with a long history, thus creating significant challenge when a desired change is required.

- Basic assumptions: these form overtime by organisations or groups –repeated exposure to the problem with a suggested solution helps reframe how and whether the group reacts based on what they understand, how they feel about it and whether it means anything to them.

Schein' states the essence of a culture lies in its pattern of underlying assumptions. He defines essence:

> "*Pattern of shared taken for granted assumptions that will be observed as artifacts, espoused values, norms and rules of behavior*."

In understanding these underlying assumptions, you can begin to understand the surface culture and work to resolve issues.

Leadership according to Schein, is there to get momentum with dealing with group problems – internal and external to the organisation. He offers that if 'leaders' assumptions become the group shared assumptions this enables the group to form their own identity, become strong, and that by this way of change the group develops their own normative behavior. He defines normative as '*based on cognitions, perceptions, and feelings*' displayed by members of the group. (E. Schein 2010)

'Integration' as a concept, features in the Clinical Governance Guidance Framework, and in Frankel, so why would integration be important relative to clinical governance and organisational culture? Once again, Schein gives insight as to the reasons why internal integration is important to organisations

Common language: to function well the group must have common language and be able to communicate clearly, including gesture, action and speech.

Group Boundaries: affect the culture by deciding who is in and who is out – and may be task focused or hierarchy focused and department focused.

Power and status: Who holds power, granting of power, earning of power.

Rules: how do we deal with authority and peers?

Reward and Punishment: sanctions, disciplinary, rewards - who gets what when and why.

Explaining the unexplainable: issues not under anyone's control – disasters etc. (Quality and Commission New Zealand 2017a; E. Schein 2010; A. S. Frankel, Leonard, and Denham 2006)

Taylor, states that a culture conducive to governance as leadership includes the need to identify what matters most to the organisation. In doing so individuals must feel able to raise issues overtly and not fear marginalisation, or that power based relationships will impede good judgment; this fostered by conversation that focuses on collective 'sense making' as an outcome of engaging in authentic conversation. Giving 'meaning' to the content of the conversation or decision in creating a '*relational connection'* by asking who, what, when, where, and then the how and why. They suggest this enables a deeper understanding and, therefore, common appreciation of the issues that require judgment and collective wisdom to resolve. This style of leadership and governance provides a more effective collaboration and shared problem solving process that promotes '*collegiality*' as opposed to

'*congeniality*' and relies on all individuals to play an equal role in the process. (Chait, Ryan, and Taylor 2004)

The complexity of large organisations, especially when introducing an organisation wide concept make the process of true integration very challenging. Sub cultures, less obvious to surface behaviors influence the likely success of introducing a process successfully. Engaging staff is frequently referenced. (Taylor, Ryan, and Chait 2013; Quality and Commission New Zealand 2017a; A. Frankel et al. 2003; Gauld and Horsburgh 2015)

Kahn, defines engagement as:

> "*The simultaneous employment and expression of a person's 'preferred self' in task behaviors that promote connections to work and to others, personal presence, and active full role performance*."

He proposes that three psychological conditions emerge as part of engagement: meaningfulness, safety, and availability. He links meaningfulness to the choice to engage, this choice being linked to the personal perceptions of the benefits of engaging such as, is it meaningful, is it psychologically safe and what benefit will the outcomes to me be? Further, he describes that individuals experience a feeling of dignity, value, worthwhileness and self-appreciation. He proposes that individuals experienced psychological safety as being able to act or be authentic without fear of negative consequences to self-image, status or career. (Kahn 1990)

Saks' looks at the antecedent and consequences of employee engagement and offers that engagement is defined as a:

> "*Unique construct that consists of cognitive, emotional, and behavioral components' and that it is not related to 'organisational commitment, organisational citizenship behavior and job involvement*."

Saks' research identified that engagement occurs at a role level and an organisation level, and that engagement in both components can differ at an individual level. His practitioner implications as a result of his study indicates that '*perceived organisational support'* is the only significant predictor of both job and organisation engagement. The '*perceived organisational support'* garners a sense of obligation in employees and therefore increases organisational and individual engagement and he suggests that organisations who wish to improve employee engagement focus on understanding the perceptions of support they receive - he suggests way to do this such as surveys, focus groups, and as well focus on demonstrating a caring and supportive environment. He also proposes that managers need to understand the importance of employee engagement and why conversations will create reciprocation in engagement; that managers should find out what is desired by staff that will enhance engagement. Engagement should be recognised as:

"*A long term commitment and requires continued interactions over time in order to generate a state of reciprocal interdependence*." (Saks 2006)

Macey *et al* , help define the differences between job satisfaction and engagement. Based on the clear benefit of engagement, understanding the difference may be helpful to managers; Macey *et al* state that being satisfied ('*satiation')* is not the same as engagement. They propose that feelings such as energy, enthusiasm and '*similar affective*' positive states become a '*facet*' of engagement and are considered '*very different states within an individual'* and that being satisfied does not represent an engaged individual. The premise of this is that engagement is active, whereas being satisfied implies passiveness. Surveys that measure satisfaction are not necessarily measuring engagement. (Macey and Schneider 2008)

How well are leaders prepared for leading? Gauld, states that tertiary education providers, professional colleges and regulatory authorities have a central role to play. He feels the benefit of a 'two job' approach whereby leaders also hold clinical loading ensures better understanding of the issues that clinical leaders face. Undergraduate preparation, followed by postgraduate leadership training help prepare and educate leaders. He links this ability to lead effectively with the core purpose of clinical leadership, such as decision making at clinical governance or clinical councils, who aim to provide clinical oversight and inform decisions. These committees, made up of a variety of roles such as management, executives and clinicians have a broad range of topics to consider in the clinical context; the ability to represent clinical and patient interests sufficiently matter and place the clinician in the central role to ensure decisions are in the best interest of the patient. (Gauld 2017)

This chapter has explored the literature offering a theoretical and practice basis of clinical governance, organisational culture and leadership. While initial changes prompted by my past leadership roles in guiding aspects of clinical governance, positioning these questions in the context of my prior work has enabled me to recast these questions in light of new knowledge uncovered as part of the project and the literature findings. The literature confirms my practitioner knowledge base in the concept of clinical governance, its overarching aim to keep patients safe, reduce error and promote quality. Literature supports my position that clinical governance is a difficult concept for many to grasp. Organisational culture literature supports this area receiving more attention when trying to mesh the clinical governance concept with existing internal cultures. The engagement process is a component of internal culture that has emerged as a prerequisite to success – something that I had not appreciated at the beginning of my project. The complexity of organisational culture theory provides evidence for improving connection, engagement and support within organisations.

The game changer, however, is the discovery of a different dimension to governance – consider the impact of a generative approach to promote insight whilst at the same time ensuring oversight and foresight. Clinical governance by its very nature should enable deep meaningful understanding between clinician and governance, and this would not only improve decisions but would foster the crucial relationships that really matter to organisations. What has not emerged in my literature is the significant role Māori play in clinical governance; I found little in the general literature that overtly addressed the

need for Māori to be fully engaged in clinical governance activities. Clinical governance effectiveness is affected by this gap in representation.

Chapter 3: Motivation

In this chapter I describe what has motivated me to undertake this work. My practice framework over the years has evolved significantly to be able to blend the components of quality with function, and be able to work effectively with staff on improvement projects and system development. My ability to achieve internal organisational goals, and as well accommodate external influencers, sometimes compliance based, has enabled me to become familiar and proficient with the language and the concept of clinical governance. Writing my review of learning uncovered my journey to this point and illuminated my interest in this whole of quality concept called clinical governance and my deep interest in organisational culture. The foundation stone or platform from which my practice framework emerges began rather unexpectedly, and cemented many of the values and professional perspectives in which I have since functioned, the sentinel point being a junior leader in the aftermath of the Cartwright report. Nursing, as a profession, did not emerge unscathed in this inquiry. Criticisms of nurses and their silence, complacency and complicity compelled those of us, even if junior leaders, to act and take the lead on establishing process and mechanisms that improved the experience and systems to which women were exposed. As well, the exposure of the internal culture struggles within the organisation identified a very unhealthy organisational culture. (Ministry of Health 1988)

My later experience in a tertiary health organisation offered a different challenge as past health reforms had supported the disestablishment of professional leadership roles. Focus was clearly on managerial culture. The patient was no longer the priority as dollars mattered more. Systems for quality audit and assessment of errors and mistakes, and improvement opportunities were minimal, and serious incidents rarely investigated. The need for systematic assessment and introduction of quality initiatives was blatantly obvious to me.

My process of reviewing my past as a professional leader enabled me to reflect upon how I have practiced, and why it matters to me; I am acutely aware that my experience is personal, and not everyone I have worked with will understand my motivation or interest. Perhaps without a burning platform, the desire to engage in quality improvement may not be a priority. I recognise that it is a struggle for organisations who are in unfamiliar territory when attempting to introduce or improve on the components that make clinical governance a whole of quality concept. Motivation is not complete without reflecting upon the human impact of error. Witnessing the professional devastation individuals experience when serious error occurs is profound, equally so is witnessing the grief and personal pain families experience as they try to understand what happened and why. As a professional leader I hold a deep sense of obligation to help others to avoid such experiences and, if this is not possible, to have the ability to work towards reduction in harm.

My goal was to understand what encourages organisations and individuals to embrace the clinical governance concept, and then be able to share identified enablers or supports that assist organisation's to actively participate in improving patient/client focused services delivery. My research included the not for profit sector to demonstrate an awareness that not all providers are government funded. Constraints such as financial and knowledge based, may exist within the not for profit sector and, hence, limit ability to engage advisors and helpers in this area of specialty. Consequences of this lack of

resource may negatively affect clients and service users, many of whom will access services for life. Not for profits might feel demoralised as they try and then fail in introducing quality improvements – and some others feel their 'specialty' is not exciting enough to get good advisors around their table. In addition, anxiety for staff and managers increase once regulatory systems start to demand audits and various checks and balances, and thus much money and time is spent hastily trying to get everything in order. This is not a value judgement by me, merely an observation based on my experience within the sector. Conversely, the privilege of being familiar and competent in this area awakened my realisation that being able to broker this topic should be a competency of mine - using language that means little to others, and processes that are unfamiliar are unhelpful, possibly further confuse or demoralise the individuals on the receiving end. And so, in answering my research question, 'how do staff describe clinical governance and the relationship with organisational culture and leadership', lessons learned from this study will change my practice to one of inquiry and understanding, and less assumption and formality, and as well assist me with formulating the practical approach that is best suited to the recipients.

My professional practice aim is to work with and alongside organisations to assist them to understand what and how they attend to their organisation's approach in leading and supporting clinical governance.

In this chapter I have explored the motivations for this work. I have explored the background to this work, personally, professionally and organisationally. I have identified an opportunity to develop new ways of approaching and working with organisations in my approach to introducing clinical governance, and improved opportunities for achieving staff engagement in this concept.

Chapter 4: Methodology

In the previous chapter, I have explored the theoretical and my professional practice context of clinical governance, organisational culture and leadership. While the field of clinical governance, organisational culture and leadership is well known, there are significant gaps of knowledge about engaging staff in clinical governance and sustaining it. Less is understood about how best to achieve this. The motivation chapter offers background about my work practice and presents an opportunity for change in how I work with organisations to achieve effective clinical governance. In this chapter I describe my underlying methodology and the detailed methods that have enabled me to undertake this work-based project in a way that aligns with my professional development.

My research project utilised a phenomenological methodology and an interpretivist framework of qualitative research (Cody and Mitchell 1996). Costley, Elliott and Gibbs' framework for work-based research guided part of the process (Costley, Elliott, and Gibbs 2010). My Academic Mentor provided supervision of the project. Data collection methods involved active discovery utilising interviews and focus group. Literature search assisted with supporting and commenting on the research discoveries.

The Otago Polytechnic Ethics Committee reviewed the ethics application. My preparation included informed consent process for phase one and two. Project information in the form of a flyer. The project was approved under category B Ethics application by Otago Polytechnic and supported by Kaitohutohu.

The core research question:

> **'How do staff describe their understanding of clinical governance and is there a relationship between clinical governance organisational culture and leadership?'**

The research aimed to explore the following information to assist with answering the question.

- Tacit links between leadership and effective clinical governance.
- Impact of organisational culture on a sustainable clinical governance model.
- Organisational perspectives on benefits of clinical governance and what matters or does not matter, to practitioners in their day-to-day activities.
- Who leads a clinical governance model?

Research subjects

Three providers of health and residential services participated. Each provider had unique service provision and leadership. Two were not for profit entities relying on income from contracts and philanthropy, and the third was fully government funded.

The first organisation was a **not for profit charitable trust**. The organisation manages 17 residential units throughout their region, as well as community support services. Employees include administration, professional nursing, allied health, care workers and lay staff, and volunteers. It is Quality Health New Zealand accredited. It is part funded by the district health board and philanthropic sources. Three individuals participated - a clinical lead, (nurse), a board director (governance), and the chief executive (management).

The second organisation was a **provider of health services**. A community owned not for profit company funded primarily by the district health board and private contracts. Community fundraising initiatives also contribute. Services include response to trauma, secondary health services and a high dependency unit. It is a training facility. Employees include medical specialists, registered nurses and allied health disciplines. It is Quality Health New Zealand accredited. Three individuals participated – a medicine specialist (doctor), a director of nursing (nurse), and a charge nurse (nurse).

The third organisation was a **medium / large district health board**. Government funded, it funds and provides tertiary, secondary, community, mental health and primary care to the population of the region. Professional clinical and academic staff deliver the services across the region. It is a training facility. It is Quality Health New Zealand accredited. Three individuals participated - clinical governance quality executive director (executive), chief nursing and midwifery officer (nurse executive), and governance.

Interview participants

The interviews were semi structured. Guided by questions based on the appreciative inquiry method (Stowell 2013).

Interviews lasted approximately 60 minutes.

The initial aim was to interview three governance directors, three clinical leads and three chief executives. The rationale for the selection was the premise that each category of clinician, management and director would have unique perspectives in relation to my questions. My final participants included only two governance directors.

Sharing information about the research and informed consent occurred prior to commencement. (Appendix A and B)

The interview question structure focused on drawing information related to the core area of inquiry being clinical governance meaning, organisational culture and leadership.

- What the words clinical governance meant to the interviewee.
- A time when clinical governance worked well for their organisation.
- What advice insights would they offer leaders about clinical governance?
- What does a successful organisational culture look like from their perspective – what gives their organisation 'heart'.
- What insights might they offer about the relationship between organisational culture and sustainable clinical governance?
- What else might they wish to offer?

Data analysis

The interviews were transcribed verbatim by the researcher.

Transcripts each contained between 4000 and 9000 words. Transcript analysis included listening, reading and identifying the themes. Categories emerged from each theme. Color-coding and notes was the method of theming.

The process of identifying the themes involved manual color-coding to identify 'related' comments, experience or descriptions that participants offered. Where there was more than one theme identified theme in the same sentence, I applied the comments to both groups of themes.

For example, where a participant was responding to say measuring or dealing with complaints, (quality process/system) and they also mentioned in the same sentence how these are associated with organisational culture,(organisational culture) I coded this by colored marker to both system and process, and organisational culture.

Overarching themes emerged as I grouped the color- coded content into clusters eventuating in dominant areas of thematic focus. Transferring the coded content onto a hand written mind map enabled me to see the emerging and overarching nature of the themes.

Once I had established confidence at what was emerging from the narrative I was able to re-analyse the transcripts to ensure there was congruence with what I had coded and themed under my key question areas of inquiry.

As further record of my analysis, I recorded handwritten notes of my thoughts and as well, transferred the majority of the hand written mind maps electronically on to a mind map template so that I was able to refine my analysis as I developed my findings. See Appendix E and F as examples.

During the interviews, I observed the way in which individuals engaged and the cues that allowed the conversation to follow areas not initially scripted that could add to the findings. I was also aware of the time constraints, the ease and flow of conversation and the moments of illumination and sometimes humor. This was important when I initially transcribed the tapes and then listened again to check accuracy. All interviews took place in private offices; this was helpful as for those less certain there was

limited opportunity to be overheard and as the interview progressed the conversations flowed naturally and perhaps more candidly than at the start. Many insights emerged at the end of the interviews once participants had become more comfortable and familiar with their way of answering and their emerging thoughts. The decision to ask the 'what else' question became important to capture those last comments.

Each category identified overlapping themes during the analysis of transcripts. During the interview process, it was opportunistic to explore aspects that were of interest to the research and this elicited information that added to the narrative.

This research project utilised a phenomenological methodology and an interpretivist framework of qualitative research (Cody and Mitchell 1996).

Costley, Elliott and Gibbs' framework for work-based research guided part of the process. (Costley, Elliott, and Gibbs 2010)

Collection methods involved active discovery utilising interviews and focus group followed by analysis and focused learning that provides the means of development of my professional practice framework. Literature search assisted with supporting and commenting on the research discoveries.

Chapter 5: Findings

In the previous chapter, I described my methodology and approach that inform the change in my work practice towards that of practitioner in clinical governance, organisational culture and leadership. This chapter describes the first task in the change program to better understand the scope of the problem in a way that suggests potential solutions for organisations struggling with clinical governance. The motivation for this scoping exercise and this specific area is considered in terms of literature and practice context. The work is then considered in terms of the overall practice change process, and finally this is considered in terms of my emergent professional practice framework.

My findings have offered a very different picture to what I imagined. This is discussed in a later chapter as part of the change in my practice framework.

What did clinical governance mean to the participants?

The concept or understanding of clinical governance is different for each individual, but core commonalities in understanding the purpose emerged. The employee's role - professional, governance or clinician – determined the level of sophistication of the answer, the language used and the understanding of the concept.

Clinical roles were not as deeply familiar with the concept; the clinicians' experience of clinical governance is what they have been exposed to – "*we have a clinical governance committee*". The committee proved to be key in their ability to describe the concept and particularly the relationships between governance, and how they experienced this relationship. They also articulated the lack of interest in clinical governance of staff working in the clinical settings, and how difficult it is to persuade anyone to volunteer to be on the committee. Preparation of clinicians had been 'vicariously learned' by seeing what happened at the committee and this directly influenced their behavior and approach to initiatives, and whether they put energy and time into either pushing initiatives forward or not bothering. The telling statement of "*Most projects don't go anywhere as we're not financial"* presented a sense of hopelessness, as did the comment that as a governance director sat on the clinical committee and therefore was able to reinforce the budget constraints any ideas were "*headed off at the pass*".

Their expertise on the topic was understood in the context of being able to advise governance and management. It *"involves most aspects of the hospital"* and focuses on risk management - "*manage these risks in the clinical sense as opposed to the financial sense".*

The contribution of their expertise was acknowledged and described as "*Issues related to governance of the institution that require a weight of clinical expertise to think about them*".

Governance interviews described clinical governance as "*part of the continuum of governance applied…translated and applied in a particular context which is a clinical context"*.

Governance saw their role as setting the direction of travel, securing the pathway forward for the organisation, and accessing the "*collective professional voice*" to inform governance about issues of interest. Governance acknowledged the need to provide adequate supports and accommodations to

enable clinical leadership to be effective. Risk management and patient outcomes "*ensuring there are systems below in the organisation that are ensuring effective outcomes*".

Executives were fluent describing clinical governance concepts. Leaving the interviews felt like having had a tutorial on clinical governance. At hand were charts, frameworks and indicators, presentations on the computer, to demonstrate the types of activity and level of sophistication that was being applied to clinical governance. "*It's about being accountable and responsible for the environment and support the health system*". Positive and negative narrative described the overall commitment of the wider organisation to the concept providing contradictory messaging about trust and values.

Executives from the smaller organisations were equally fluent, but not familiar with a specific definition. They described examples of clinical governance activities and detailed benefits; the focus on making it mean something to the staff and community emerged strongly. Whilst a framework was available in one organisation, the choice of framework to introduce the concept was a key decision for organisational fit.

> "*Governance is often business related finance rather than outcome focus…the clinical governance component is about what the residents receive, how do we maintain and build on the outcomes, infections, fewer falls…it's about the focus on clinical things."*
>
> "*I think having a framework that actually makes sense that people can actually understand and see how it all fits together is quite important, I mean like things put into a pictorial way of how things connect with this and that and then what do we expect to see…use the language people understand.*"

Commentary and discussion

My experience when asking this question resulted in surprise; I had entered my interviews imagining that everyone would be familiar with the concept, and especially those that were delivering a combination of clinician and management roles. Almost all of the literature reviewed quoted a definition of clinical governance, the most common being Scally (Scally and Donaldson 1998), and given that this definition is quoted in the health and quality commission 'clinical governance guidance for service providers'(Health Quality & Safety Commission New Zealand, n.d.) Distributed in 2017, I had imagined most leadership staff would have read it. This finding supports my original personal hypothesis that few staff understand clinical governance – it is neither introduced nor explained as part of induction, and neither are health professionals informed or prepared for participation or leading clinical governance during undergraduate study or postgraduate roles. This is supported by Gauld (Gauld 2014) and (Gauld 2017) who describes it as "an indistinct concept", and notes that less than 50% of clinicians surveyed felt they had an understanding of the concept.

Frameworks and quality improvement emerged strongly in this first question for some of the participants in executive and governance roles. Clinicians took longer to uncover their comments about improvement which was a little surprising, and these emerged later in those interviews. When clinicians did bring up quality improvement, they were specific about the things that they saw as quality improvement – key indicators related to medication errors, and harm such as falls, pressure areas.

Complaints also emerged, but featured in close association with culture of the organisation. Peer review also emerged in one instance – this considered an important aspect of clinical audit. The conversation related to peer review proposed the possible benefits if others took part, and this then moved to organisational culture discussions related to trust.

Words used to describe quality improvement by executives included clinical excellence, improving patient outcomes, audits, using data to persuade clinicians, benchmarks, managing risk and ensuring a systems approach, reducing harm and error, safety, no blame culture, mortality and morbidity, reporting on incidents, just culture, engagement, committees, quality plans, leadership rounding, connection with staff, and no time to do it all. Governance focus was on managing risk and measuring what matters - integrating the clinical governance into the wider governance function. Governance expressed that boards needed more clinical representation around the board table due to lack of expert knowledge - "*the majority don't understand what these clinical indicators are*", and "*it's about continuous improvement, it's not just a compliance activity*", and "*manage these risks in the clinical sense as opposed to the financial sense".*

Framework requirements, sometimes referred to by participants as guidelines model, emerged in two organisations. A recently released framework document (which was not to hand but was spoken of frequently) in one organisation clearly held significance related to being able to introduce clinical governance effectively. One participant was intimately familiar with the contents – sharing the contents was the challenge for this participant to bring people on board "*you've got to engage with the tribe and get them on board".* For another, the need for a quality framework was a priority - *"we desperately need a quality framework".*

Another organisation was more interested in the philosophy behind the framework they chose to fit their organisation, "*I think having a framework that actually makes sense..."* emerged strongly, and the ability for staff to be able to connect with the purpose "*how things connect with this and that and what do we expect to see*" drove the decisions when choosing.

Commentary and discussion

A physical framework appeared to be a tangible artifact of evidence that clinical governance was happening. Satisfaction and engagement with the framework appeared higher with the organisation that had chosen their framework for best fit, whereas the other organisation adopted the policy led document. The components or data that informs clinical governance were listed really well - some more fluent than others, but overall the 'parts' of clinical governance were identified. Lack of '*buy in'* to the framework requirements by staff raised in me a sense of dissonance or disconnection between the leader and their view of '*got to get on board*'. Frameworks feature frequently in literature (Scally and Donaldson 1998)(Health Quality & Safety Commission New Zealand, n.d.)(Quality and Commission New Zealand 2016). Clinicians interviewed identified with processes such as number of complaints, incidents, as '*objective'* evidence that gave them some emerging indication of performance. However, unexpectedly, when discussions of harm or error came up with clinicians the nature of the discussion linked with organisational culture as they felt "*they nearly always involve some aspect of culture*".

The role of the clinical governance committee

The committee emerged early in all interviews; at first take, the committee commentary could easily be overlooked as it existed as a statement, it was after all *just a committee* (researcher words).

Participants opening statements included:

> *"Clinical governance here that meets every second month and has a terms of reference."*
>
> *"A clinical governance framework committee."*

There were differing expressions of significance placed upon the committee; however, the bringing of people together to have a 'collective clinical voice' was significant. The actual committee purpose and understanding of the function of such a committee differed depending on the participant.

Governance in one organisation saw the committee as a significant contributor to their governance activity. The key point that emerged here was the ability as a governing member to understand the data and implications by accessing the collective "*professional voice*". What also emerged was the requirement to trust the '*collective professional voice'* and management not to interfere with the views espoused by the professional - even if management thought differently – because '*respecting and valuing'* the contribution of clinicians was imperative if good clinical governance were to function. That did not mean lack of robust discussion, it meant '*engaging in meaningful discussion'* and ensuring ways to achieve that discussion was '*created and sustained*'. Providing '*mechanisms and accommodations*' were provided in this organisation, such as administration support, time, formal recognition and job expectations, to ensure this committee work could happen effectively. Governance for another organisation was a mix between representing the clinical voice as a board member and conveying the clinical governance reports and discussing at board meetings. The focus here was on the board members being competent to understand the data, which is a different approach to the first organisation that relied on discussion and debate between clinicians and board.

Executives saw the committee as important – '*floor to board',* but said less about the committee overall. One executive was disappointed that as a manager their role was no longer in attendance at the meeting – a way to ensure '*management didn't influence clinical decisions*' because of financial constraint. Later in this organisation, the role of board member attendance at the committee was discussed and seemed to do exactly that - constrain progress because of financial constraints and so a contradiction appeared that I do not think had been, or has been realised. Other executive participants spoke of the function of their committee, that it was still developing, not functioning as well as it might be, and why the framework and quality framework could be helpful. One organisation spoke of the committee as one that has been around a long time - meets regularly, knows what it measures and reports. There was significant discussion about feedback to staff and the need to make it meaningful to the frontline staff. Injecting new blood into the committee was thought of as helpful – *"same things get discussed",* and there was no time to explore new research or offer alternative ways of working. "*Some measures"* need reviewing. "*No one wants to join the committee because it's not sexy*".

Clinician interviews offered a very different perspective. "*We have a terms of reference... typically*

broad" and *"finding the right things to talk about is quite ad hoc", and "we don't necessarily hear back a lot about whether it was listened to".*

Comments also emerged about the role of the committee and leadership. Some saw the committee as a way to focus on clinical decisions and avoid looking through "*the financial lens".* For some it was the way to maintain the clinical voice "*how we give it more voice, what's happening from the clinical governance end".* Frustrations emerged frequently in this group and covered a wide range of issues. Feedback from the board, or lack of it, emerged a huge frustration and expressed in a few ways

"*they think clinical governance is a box to be ticked and they're perfectly happy the box is ticked…whether anything or nothing comes out of the box is of no great concern to them",* and "*I don't think we hear back from the board in any formalised way*".

Some struggled with keeping a future focus - "*lift your head up and see where you are going*". Associated with this was the lack of experience in clinical governance around the table and the benefit more experience could bring. The '*Knowing*' what to raise as a clinical governance item was also confusing for this group. Some felt the committee was not the optimal way to raise small matters, but also felt the process for raising issues was not well defined for them to follow either, and that the burden or responsibility to raise issues laid squarely with them as clinicians. The comment "*you might think the board would be a significant source of input"* emerged. The other strong comments related to the energy to develop initiatives '*a push up the energy slope",* and then the disappointment of not being able to progress due to lack of finances. "*Headed off at the pass*" emerged related to the presence of a board member on the committee. Whilst this on one hand allowed for two-way conversation between clinicians and board representation, it also appeared to stop initiatives progressing due to messaging about lack of finance.

Organisational size appeared to matter to clinical governance decisions, as relationship are closer "*it's a small place and the board is trying to do their best…there isn't any point in pushing all the time"*.

Commentary and discussion

So why should the way a clinical governance committee functions matter? This section presents leaders and governance with some crucial opportunities. We should not underestimate the importance of a secure and strong relationship between clinical governance committees and the board. There seems to be a crucial connection between the clinical world and the policy / process / governing relationship.

Taylor, in Governance as Leadership describes the benefits of management and governance working in a '*generative*' mode, thus encouraging discourse that provides insight to those engaged in the discussions at hand; the need for collegiality, making good use of the human 'capital' and nurturing respect. (Taylor, Ryan, and Chait 2013)

This is a significantly different approach to the historic governance separation of management and governance such as Carver's model of means and ends. For most, the boundaries between board and management have been clearly enforced; those who deem to cross those boundaries are frowned upon, even to the point that management are not encouraged to share information with board members. The difficulty of this historic style reinforces the opportunity for governance decisions to occur in ignorance or isolation. Given that clinical governance is about safety and quality, one would have to ask what the sense is in not considering improved ways to work as one to reach informed and insightful positions on

the things that really do matter in health.(Carver 2013)

Power is an important consideration in meeting dynamics and will affect the way a group or committee performs, and so organisations may wish to consider who attends versus who '*is in attendance'* – as this is likely to influence the nature and openness of discussions. The point here is that this is a clinical committee – the "*professional collective voice*", and so a question should arise as to what is the role of management or board on such a committee.

Sophistication of language possibly is not that important and, indeed, removing the trimmings, so to speak, may well make the relationship and meaningfulness simpler for the majority of staff. (Flynn, Burgess, and Crowley 2015a)

The coming together of the group is a solid artifact that endorses the authority of the clinical governance role or function.(E. Schein 2010; Travaglia et al. 2011)

The outputs of the committee form the objective material generated to evidence the meeting occurred, but the relationship and feedback loops between the board and the committee are clearly more important to the clinicians to ensure information is understood debated or analysed. The committee also gives a legitimacy or formality to the role the clinical governance function plays within the wider sphere of governance and, therefore, attention should be paid to how well it is understood and functions.(Gauld and Horsburgh 2015; Argyris 1977a)

So why would this matter to clinicians? The feeling that the committee creates seems to be one of connection with the reality of the world in which they function, as well as establishing stronger and more cohesive relationships. There was a real sense of commitment to the committee in the interviews – even though there was some confusion and ambiguity about its effectiveness, which permeated some more than others. The way clinicians feel about their committee on one hand suggested it was important and necessary, and on the other a slight nuisance factor, especially if resources were slim to get papers and reports written. Disappointment expressed that as a committee it is considered interesting enough for others to want to become involved – this, I felt, linked to pride and belief in the services offered. From my experience of the interviews, it matters to clinicians because it demonstrates respect for their professional contribution. These observations are related to the antecedents of engagement, values, and culture of an organisation. (E. Schein 2010; A. Frankel et al. 2003; Saks 2006)

Leadership representation at the clinical governance committee appears to hold significance, and this further reinforced positively and negatively by having board directors in attendance. There was from my analysis an unrecognised disadvantage to governance being present - it appeared to put clinicians 'off' pushing issues – especially those with less experience in governance meetings; the presence of a governing member stymied progressing issues that may matter, especially in smaller organisations. Schein offers that cultural behaviors are formed by covert frames of reference, and that we see the behavior that results, but we often cannot see the forces underneath that cause the behavior. What I heard, though, from my perspective was that stability in relationships matter in smaller communities, and on reflection Schein also speaks of '*rules of the game'* - those unwritten rules for getting along in the organisation, or '*the way we do things around here*'. (E. Schein 2010)

Size of the organisation might matter in relation to clinical governance. The nature of relationships change when communities are close and possibly creates coziness; this makes it difficult to become the nuisance factor when consequences are very close to home and challenging discourse that undermines

positions of authority. Taylor, however, would see this as an opportunity to take a more generative approach to the issues, but Saks might argue that the need for psychological safety will dominate in such a situation. However, that opportunity is dependent on the competency the board representative brings to the table, and the willingness to engage in a different approach. To work towards understanding the issues and consequences requires a conversation that retains respect in the relationship, is based on a willingness to debate and disagree if need be, but also leads towards decisions based on inquiry and comprehension by each party. (Saks 2006; Taylor, Ryan, and Chait 2013)

Leadership "floor to board' connection and communication was stated as important to executives and this reinforces individual professional accountability, especially related to knowing what's happening in the '*place*', and subsequent goal of building trust between staff and leaders to encourage sharing when things go wrong. (A. Frankel et al. 2003; Saks 2006; Travaglia et al. 2011) However, the ability to achieve such a lofty goal was clearly difficult for those in large organisations, and so I experienced a sense of dissonance. Whilst it was clearly an espoused value, I could not hear the when or how to achieve; May describes 'behavioral integrity' as consistency between words and deeds – known to me colloquially as '*do what you say you will do'*. The intention to connect emerged several times throughout the interview. (May, Gilson, and Harter 2004)

Choosing 'committee' members to enhance effective functioning deserves consideration, as does ensuring staff have enough time to perform effectively. One organisation had strong commitment to nurturing the committee and commented on the need to support and accommodate those clinical leaders to be effective outside of the committee. Saks has found that '*perceived organisational support*' is a significant indicator of both job and organisation engagement, and so managers would do well to consider what matters to employees in engaging in this committee. (Saks 2006)

Overall, the clinical governance committee is seminal to a strong and robust relationship between clinicians and governance boards and literature support this position. Organisations may benefit from considering the current status, function and membership of their board including the mechanisms for chairing the clinical governance committee. Securing effective feedback and engagement with staff about clinical or other issues that affect clinical delivery and practice could enhance the functionality and end result.

Organisational culture and leadership

Success is dependent on the strength of relationships. The absence of a relationship, good or bad, relying solely on process was thus summed up by a participant - "*is never really going to take you where you need to get it to, it's always about the people*".

Ownership of clinical governance by the organisation emerged as important; this especially so as aspects of clinical governance focus on error – and a no blame culture – trust in colleagues came through strongly in this area. "*People feeling able to trust and say this didn't go well."*

Governance focused on creating a vision for the future and a direction of travel for the organisation:

> *"[A] pathway forward…our challenge is to ensure that the key elements of that are owned by the organisation because then the pathway is secure*…"

Securing ownership by staff featured as a means to create action and maintain momentum. How to achieve such an objective as ownership was described by being willing to engage and nurture relationships. Respecting professional views and valuing the contribution of those identified as leaders who were already highly engaged was crucial. Recognising the '*shiny stars*" also engaged individuals. Equally, recognising and understanding the history of the organisation mattered to those in governance. This appeared to give governance purpose and clarity about why they governed. Engaging effectively was described as "*not a one off approach*" – it takes skill and resilience and tenacity to keep going back until you get to a place whereby you can have "*a reasonably open and positive conversation*".

Governance also spoke of the authenticity of engagement and the need for it to be consistent and sincere:

> "*Engagement can never be a one off kind of affair, engagement has to be continuous and it has to be sincere so it's not just something you can just kind of pick up and use when you think you might need to and then kind of ignore*...".

Clinical governance committee was described as the forum for the "*collective professional voice*". Governance needed to be clear with clinicians about their role in clinical governance, how they could be supported to achieve the work required for effectiveness. The feeling of professional respect and valuing individuals emerged during the interview. Discussed also was the "*weight of clinical expertise*" that clinicians bring to the table. Knowing the activities of the leaders in the organisation also emerged - reinforcing the connection between management and governance.

Artifacts or rituals that governance were aware of included leadership rounding (visiting the clinical place in person), ad-hoc visits, local organisational recognition programs (employee of the month), and annual awards linked to the connectedness of the organisation as one team.

'Valuing' emerged in the governance interviews numerous times. What did valuing mean and how did they know that what they did was valued?

> "*A fundamental attribute that underpins a way of being*" and *"ways of doing"* and "*whatever these things are that at an organisational level we place value on.*"

I asked how they know. "*Continued willingness to engage*" was the answer.

I also inquired about how it became evident that people did not feel valued. The answer was that people simply did not engage - "*if there were discomfort the barriers would go up"*

What did executives say about organisational culture and leadership? There were some commonalities. Words such as "*a just system"* and "*I'm accountable for a safety culture*", "*I feel accountable for making sure clinical concerns are elevated*", "*visible leadership is important to me*". These themes emerged many times throughout the interview. The theme of engendering trust also emerged and linked back to the need for engagement and being visible - "*walking the floor*" and "*what you want is for the staff to be engaged", "walking the talk so never breaching trust, always being transparent and open".*

The intrinsic belief that living the values of the organisation is crucial to being an effective leader came through strongly. The language and consistency in this messaging was powerful. Another key thing was

mention of the external role of leadership, being the policy makers who seemed to influence aspects of their roles differently and seemed to drive some of the activities such as reporting.

The "*no blame culture*" emerged as a goal of clinical governance. Words such as '*you've got peoples back" and "culture of fear"* were expressed to demonstrate that in a functioning clinical governance system staff should be able to feel safe admitting to errors or near misses, and receive necessary support to work through what happened. "*Communication is the biggest killer in hospitals*". Associated with this was the recognition that staff will only engage in such conversations if they trust the system and leaders to support them. Perhaps one observation of this discussion is that there was an element of dissonance that emerged as a frustration that staff "*didn't get it"* or "*were suspicious"* of the process. Incongruence occurred between describing desired actions of staff and that of nurturing the trust and valuing individuals.

Survey of staff satisfaction and occasional culture surveys were measured by two organisations. For one organisation the word 'measures' was about objective ways to measure, but the essence was what they felt when they '*walked into the place'*.

The key message from those using survey was to use the feedback information well – take it back to the staff and discuss the actions needed to respond to the feedback. The appreciative inquiry method appears to have worked well for this work based on its ability to look for the positive and engage staff in solutions. The key message was:

> *"You don't embark upon it lightly because at the end of the day the really most important thing is that people see what you are doing makes a difference."*

Responsibility for the teams emerged to ensure support and enabling growth and skill. For smaller organisations, this presented as a challenge to keep staff settled in the smaller environment the analogy of staff "*getting itchy*" and the solution "s*cratching the itch*", in other words providing other stimuli to help keep staff focused and refreshed. This also related to respecting staff experience "*everyone's got their own pocket of knowledge they can bring to the team",* and identified that whilst frameworks are helpful, staff being able to use the tools practically is important. Therefore, understanding the language associated with clinical governance needs to be in the context of the organisation.

Clinicians expressed their views differently about organisational culture. "*I would say it is assessed every time you go to work."* Body language was clear in this interview - the connection to the heart made clear as the interviewee gently tapped their chest as they spoke. Culture is what it feels like "*when things don't go so well…which are often clinical questions but they nearly always have some sort of reference to the culture of the place*". Trust emerged strongly related to the practice within the clinical environment and the desire for everyone to work well and safely. Teamwork and reviews of practice also emerged - the notion that trust develops if discussions are multidisciplinary emerged. "*In rural you work together completely and you're totally dependent on one another."*

Individual skill sets were appreciated and teamwork and collaborative decisions. "*To get disciplines around the table and have an equal say*". Effective communication mattered as well as did courage -

"*they weren't scared to escalate things"* and "*be brave enough to do it*", especially related to reviewing clinical errors.

The experience of the clinicians not being valued emerged. This related to lack of feedback from the board; this appears to create dissatisfaction and maybe implies lack of respect for the work and contribution individuals make.

> "Y*ou don't necessarily hear a lot back from the board whether it was listened to or acted on so I think having some loops of feedback more circular"*.

When asked if that was important - the link to the board: "*To the board, yes Probably.*".

One clinician summed up what good culture meant:

> "*Well it would be a mixture of good things and not so good things…clicks of unhappy people, perennial issues, repetitive issues around the same thing…people basically being happy at work…to come to work participate and do a good job.*"

Commentary and discussion

So why should this matter to organisations?

Safety, trust and demonstrating of values are crucial to clinical governance buy in. Leadership and culture appear inextricably entwined in the clinical governance world. It is difficult to write about one concept without considering the other as each seems to be dependent on individual behaviors or attributes forming the collective experience. The *how* individuals speak of their values and behaviors and what they need to do to demonstrate them appears to be influenced by their formal role and responsibilities; however, the '*what'* they do to address the values and desired behaviors did not emerge consistently across interviews. Congruence of words, feelings and actions were present for most, however I also observed incongruence of words and body language and some dissonance when speaking of what was wanted and how the connection or engagement was going to be delivered by the organisation. Trust and individual safety are clearly a key need or aim for those interviewed. The desire of creating an organisational culture of safety emerged, and this related directly to high engagement and trusting relationships.

Connection, engagement and setting a direction and purpose is the game changer for organisations. Making clinical governance meaningful to staff also mattered. Using tools and frameworks as enablers help guide the process. To be a good leader, and take individuals on the journey requires consistent leadership behaviors and demonstrating a clear respect for those individuals they are working alongside. Sometimes this means the leader moving outside of their comfort zone to seek engagement opportunities even when barriers appear. Insights include ensuring that staff feel they understand the terminology – which means changing the terminology to fit their environment and daily language. For

others it means offering education and getting leaders and clinicians ready to engage in clinical governance conversations – apart from one participant who has worked in the clinical governance arena for many years most others learnt "*on the fly*".

The leader's role is to lead, support and enable staff to perform. To achieve this the leaders also need to be clear of the direction of travel for the organisation. Therefore, one can suggest the relationship with governance is crucial for effective leadership. Leaders also need time and clear accommodations to do their job well. Teamwork is important for good safe performance and enhances trust and the smaller the environment the greater the need for trust in each other.

Kahn examines the psychological conditions required for engagement and disengagement at work. For most of us, the idea of engagement is in the connecting and discussing, the conversation and mostly, this is superficial in the business of the day. Kahn's work found the conditions that influence an individual's ability to be fully engaged includes:

> "*Varying degrees of themselves, physically, cognitively, emotionally, in the roles they perform*."

He also wanted to understand what disengaged individuals, sometimes referred to as self – estrangement with indicators such as absence from work. Kahn's definition of engagement:

> "*In engagement, people employ and express themselves physically, cognitively, and emotionally during role performance."* in disengagement he defines it as "*the uncoupling of selves from work roles; in disengagement people withdraw and defend themselves physically, cognitively and emotionally*." (p 694).

Kahn describes the notion of personal engagement as when an individual become involved in their work in such a way that they are connected cognitively (aware of what's happening around them) empathically connected to others and able to display what they feel and think, their beliefs and values and feel connected to others. Those disengaged, *'withdraw personal connections, physical, cognitive and emotional absence, and passive incomplete role performance'.* (Kahn 1990)

Sometimes this is referred to as impersonal, closed and occasionally this is called burnout. (Maslach 2001)

Kahn states that three psychological conditions exist that require considering before an individual will become personally engaged and these relate to meaning, safety and availability.

- Psychological Meaningfulness relates to performing roles that are interesting and challenging, feeling valued, sharing in the course of the role of work, having recognition of role, in influence or autonomy, being treated with respect personally and professionally.
- Psychological safety is being able to be open and honest without fear of negative consequence. Trust in colleagues, fair processes related to consequences and behaviour of others, openness,

non-threatening. Leadership that promotes resilience, consistency, trust and competence all supported by '*organisational norms'* and group dynamics that support shared expression of openness and trust.

- Psychological availability – not being distracted by other pressures or issues, having energy physically, having emotional energy, feeling like part of the team, that you fit in, and not worrying about performance anxiety or self- conscious of others.

Kahn's study highlighted that when individuals, regardless of role, had meaningful interactions with others at work it promoted dignity, self-appreciation and a sense of worthwhileness and feeling valued and valuable. Conversely, those who did not experience meaningful interactions absented themselves psychologically. (Kahn 1990)

So why would Kahn's work matter to the findings of my study? *'It's assessed every time you go to work' and 'generally happy to come to work and participate and do a good job'* possibly sums up the significant place leadership culture plays on the individual willingness to engage within an organisation. Interview participants spoke frequently of trust, value, safety, respect, engagement; the conditions to support effective engagement were described as "*creating the structure"* to enable engagement opportunities. Being engaged was assessed by interviewees as the "*willingness of staff to continue to engage in discussion*", even if this discussion was difficult or challenging. This appears to be an important measure of whether staff feel able to participate and feel comfortable with the consequences of engaging – and also the willingness to share conversation and be prepared to contribute to solutions and planning, and decision making process.

However, what also emerged during interviews was a concern expressed that there is some lack of willingness of staff to connect and participate in clinical governance activities – review of error and audit. These concerns related to error and learning from error, and in light of Kahn's work this is something that requires further consideration. Discussion about the future organisational direction, measures, systems and other issues that are clinical governance contributions, are not perhaps 'personal'. When individuals are personally involved in error or serious incident, Kahn's work suggests that they are likely to disengage if the psychological conditions of their individual work environment are not safe. This is crucial for leaders to be aware of and consider ways of addressing.

Māori contribution to clinical governance was minimal

Cultural commentary was lean during the interviews and nearly always needed a prompt to seek a view. All organisations had some Māori signage. No interviewees identified as Māori. One organisation expressed their cultural commitment as a "journey" on which they had embarked some years ago.

When asked about bi-culturalism:

"No I'd say it's not but I think we are on a journey it probably started in earnest about three years ago and it's grown gradually getting more and more and it will continue to grow, it has to."

Others acknowledged Māori and then focused on multicultural influences:

"Every client we have comes from a different culture, the culture of their household, wherever that is…so the trick is to work out what's right for them."

This was linked to the workforce which was sourced from many countries and added variety and also complexity to the organisations cultural situation:

"We've got an international workforce…Sometimes that's a mismatch between expectations from one party to the other."

One participant was blunt about their assessment of biculturalism:

"*Good question. I would say for the most part we are really crap at it…it's got to be integrated and threaded throughout everything…what I struggle with in that space…We're not very culturally aware.".*

Other comments deflected leadership of biculturalism:

"We've got to get a whole lot better at it…the Māori is important because when you say culture here they think Māori…but we've got to start there.".

"We are working closely on how do we know something is equitable, how do we address unconscious bias…how's that going to translate into Māori or Arabic."

The word dissonance probably found its rightful place during this section of interviews. Other words I would use include confusion, lack of awareness, and reduced sensitivity and the conversations were awkward. Some participants struggled to respond:

"Not really I don't think, no I think it's probably difficult in terms of bi-cultural in this area."

A last minute conversation with governance acknowledged that the inclusion of Māori around the governance and clinical governance table was a key commitment of the organisation. The offer of connection with a cultural advisor was welcomed by the interviewer, however ultimately connection was unsuccessful. Further reflection is necessary to appreciate new ways of engaging with Māori around clinical governance.

Commentary and discussion

So why should this matter to leaders of clinical governance?

Interviewees found this area of questioning challenging and uncomfortable. Organisations superficially have made small steps towards acknowledging biculturalism with visual artifacts such as translated signage. Gaining access to Māori organisations to contribute to this project was unsuccessful, and affected the quality of information to inform this research. The scope of this project was unable to extend to discovering the reasons for the lack of response during the interviews and to the researcher request for participation. However, given the significant role Māori participation plays in clinical governance, including honouring the Tiriti o Waitangi, it seems that there is an opportunity for organisations to consider their role in engaging Māori in the clinical governance process. Perhaps understanding the barriers to this engagement might be place for future research.

What else finding?

Organisation size appears to affect the way in which relationships form and the influence of these relationships on clinical governance initiatives and activity. Smaller organisations with strong close community relationships appear to have improved flow of information, which on the surface seems a good thing: it does, however, from interview comments appear to stop progress of initiatives because "*things are headed off at the pass",* and the personal connection appears to create complicity with such outcomes. Larger organisations appear more disconnected from their main audience and sharing of information is difficult, often without any certainty that those that could benefit are considering it. This fosters a different feeling – that people are disconnected, disinterested, and not committed. Both of these are assumptions based on the information in the interviews and the way in which participants spoke of their environments and relationships.

Education about clinical governance as a concept emerged and the realisation that mostly health staff are not educated or briefed about this topic in undergraduate training. The general notion that most are relatively clever people that work in a complex system but have no preparation in an increasingly present topic raised question of why it is not in curriculums during training.

Interview as intervention. Interviewees appeared to enjoy the conversation. For some the conversation enabled a forming of views, or an opportunity to reconsider their current knowledge base on the topic.

Perhaps most significantly, the interview and self-reflection on the topic enabled a change in approach to, and practice in, clinical governance.

People - the staff are clearly the key to success in implementing effective clinical governance. Treating clinical governance as a project simply does not work. People as opposed to process. Letting people discuss and talk allows "*for gold to come out*".

Commentary and discussion

Health professionals need education in clinical governance. Gauld identifies that the concept is '*indistinct*' and therefore not well understood by health professionals. He also promotes improving leadership training opportunities to enable clinicians to straddle the two areas between leadership and clinical practice. Organisations, therefore, may benefit from considering the gaps in knowledge of the staff they expect to play a key role in clinical governance activities. (Gauld and Horsburgh 2015; Gauld 2017)

Dynamics and relationships, appear to be influenced by size. Larger organisations struggle in connecting with every layer frequently enough for it to feel consistent for those interviewed, and smaller organisations experience closeness and, therefore, the familiarity and camaraderie possibly has potential impacts when pushing issues resulting in a risk situation for one party more than the other does.

Saks' has demonstrated that perceived supervisory support is a key indicator of engagement; perhaps organisations need to consider the how to achieve and optimise structures that would enable staff to have opportunity to feel connected to their leaders. I felt there was insight in some interviews as to why staff disengage – one participant was particularly insightful and comfortable facing the fact that people in organisations have past '*baggage'.* Addressing this 'baggage' is the first step to engagement such as openness to hearing what needs to be said before progress in connecting can occur. Their pragmatic approach included acknowledgement that past issues could not be resolved, but getting the individual into the space whereby they could move on was important to the leader. Saks' work reinforces this approach indicating that employee engagement requires consistent, long term continued approaches to nurture a sense of reciprocity in the individual. (Saks 2006)

Kahn and Schein's work may highlight weaknesses in relationships that are power based because of role. I felt this issue emerged very *quietly* during the discussion about board members attending clinical governance committee meetings. A hint of deference or "*understanding the rules*" towards the board member subtly emerged:

> "*The board are doing their bes*t", "Y*ou know it's not meant to be overseen by someone higher up, or anything like that…it doesn't allow our process to continue when we hear about financial constraint…in some ways its good, we get to hear about things...but we don't get to progress things because we know there's no money…there's no point working on it."*

Could this be a subtle control mechanism that could be conscious or sub conscious; perhaps in smaller organisations staff have increased need to feel belonging and safety because of needing to maintain enduring relationships and with limited options for similar work in the community dissent may have significant risk. The impact on clinical governance should be concerning as clearly there are subtle boundaries that there is discomfort for staff in overstepping. (Maslow 1943; E. H. Schein 2010; Kahn 1990)

Chapter 6: Discussion of Findings

As introduction to this section, I review the clinical governance, organisational culture and leadership practitioner insights that have emerged during this work. Each of the stages in the project is explored in terms of the change in work practice and the impact of that practice. The review is done in the context of leadership, organisational culture and clinical governance as explored in my literature review and knowledge of prior practice. I reflect upon and examine the extent to which this contributes to advancing that field in theory and practice and the limitations of those findings. This and a revising of the original motivations from the work lead to suggestions for further research.

During the early phase in my study I discussed the purpose of my research discovery, and the motivations, based on my prior experiences. There is no doubt that my personal experience in practice and leadership formed my current assumptions that have inevitably framed the way I have worked in this area. Insight is enlightening and offers me the opportunity to review my prior assumptions with the goal of re-framing my way of working in the clinical governance model. Theoretically, the ability to apply methodologies identified in the research process of interpretivist and reflexive processing has helped me to make sense of what I have heard and synthesized during this phase of the project. (Cody and Mitchell 1996)

Key learnings at this point have evolved to reflect my research findings and then further informed by the literature. This leads me to recognise that clinical governance is a complex topic that is understood by senior staff, and less so by clinicians and junior staff. Successful leadership of clinical governance is highly dependent upon organisational culture, this being the artifact of leadership values and behaviors. Staff ability or readiness to engage based upon their perceived relationships with leaders including the support leaders provide influences their level of trust and psychological safety in their work environment. Applying these learnings to my research findings collectively enable me to propose that organisations and leaders should consider exploring the following key suggestions:

- Clinical governance should not be treated as homogenous group subject; it is made up of many components that create the whole.
- Clinical governance committees are seminal in the relationship between floor to board communication and foster professional respect and collegiality.
- Clinicians need to be better prepared to participate and lead clinical governance.
- Staff engagement should not be confused with staff satisfaction as the two are quite different.
- Organisations should foster the connection good engagement affords.
- Leadership equates to respect, trust, valuing others and being fair and just.
- Staff need to feel psychologically safe to perform optimally and engage fully in their work role.
- Boards could improve function and relationship by considering *how* they engage in clinical governance with a view to understanding relational needs of participants.

- Staff willingness to do a good days work and engage is indicative of the health of the organisation.
- Frameworks are useful to guide process but are not the driver of clinical governance.
- Taking time to understand why staff engage or disengage can assist with understanding what needs attention within the organisational culture.
- Smaller organisations have challenges that are different in nature to larger organisations especially related to power and authority.
- Strategy and definitions are not front of mind for staff in day to day work.

Chapter 5 explained specific findings. I have referenced current literature and offered brief commentary at the end of each section. Those findings represent overall analysis of narrative and offer quotes and observations; the following overarching flavor of the discipline content tells the story that eventually unfolded for me during my discovery and informs suggested work activity for future practice.

Clinicians

Clinicians interviewed demonstrated they were insightful but pragmatic; just get on with the job at hand – applying a label to the behaviors or activities had not been thought too much about until the invite for an interview. They like their work, and want patients to get good care. They know about complaints and incidents, and committees and key performance indicators. They know how it feels when they walk into the place in the morning. Objective measures of culture do not matter - subjective matters more. They know what the perennial issues are that create irritation. They say that incidents are nearly always linked to the culture of the place. They do not know too much about the theory or application of clinical governance as a system, but they know it is a committee and has process. They have learned it "*on the fly*", and there is not much expertise on it around the meeting table. It is repetitive and same old stuff. They know if they raise issues, its hard work – "*push up the energy slope*", and they have less time to do other things if they have to write reports. They go to the committee and create minutes, people do not read them, and mostly they do not hear much back from the board. They do know, however, that they have the expert knowledge, are there to advise the board, and carry a weight of expertise that addresses clinical matters. The things that matter most in the organisation and give it heart are the people.

Management

Management interviewed offered a sophisticated picture of clinical governance. They offered definitions, quoted frameworks, quality plans and processes, and rituals of leadership and expectation of the boss. Spoke of busyness, lack of engagement, or high engagement, culture surveys, and no one size fits all. They spoke of trust and professional accountability, the risk if trust is broken and the ways to engender trust. They spoke of the committees in a slightly negative way, indicating function was not as good as it might be. They referenced relationship to governance and the significance of this relationship. They spoke of culture - just, supportive, blame free. Staff development, learning from mistakes and audit. Risk management. Lack of time to connect with staff was a worry for some. Finding enough time to get it all done was also a worry. Walking the talk mattered to some. Some were happier than others were. Professional accountability was strong. Professional respect was strong. Putting the patient at the centre of what they do was strong. When asked what matters most in the organisation and gives the organisation heart - it is the people.

Governance

Governance interviews demonstrated commitment to the organisation purpose. Strong sense of direction, knew where they were heading. Valued the clinical voice at the board table. Strong accountability for achievement and delivery of services. Respect for the staff. Articulated the value of clinical governance. People not process matter. Not compliance. Understood risk and systems. Committed to recognising the value of leadership and good engagement. Worried about lack of clinical wisdom around the board table. Spoke of the value of conversation. Understood the history of the organisations. Articulated their mission and role in governance. Not all decisions are about money. Do not get distracted and lose sight of what matters was a key message. What gives the organisation heart? People feeling valued and being prepared to engage.

So what does this mean for an organisation and its leadership approaches? All of these individuals value relationship and engagement; it matters to everyone I interviewed. Feedback is considered a key component of respectful engagement; therefore, lack of feedback is unsatisfying and reflects lack of valuing the opinion offered. Feeling valued encourages individuals to "*do a good job*". The challenge for organisations, big and small, is the 'how' to achieve satisfying and respectful engagement, and one of these approaches needs to be to address the characteristics of the group first, and then attend to the learning needs that fit the way they work.

So what are the conditions or influencers' management might consider to create an engagement process that is sincere and consistent? Smaller organisations appeared to foster closer relationships and become personally connected to the people and community compared with the largest organisation. They know what was happening in the hospital and the community. The conversations were warm and supportive of effort. The 'flavor' of these interviews articulated that the staff 'talked' frequently and openly with peers, management, and board representatives. One unexpected

observation that managers need to consider is that objectivity may be harder to achieve in smaller communities, especially around the board table. Awareness of this might be useful, especially when coaching junior staff - the skill to conduct courageous conversations, as well as maintain the relationship, is a skill learned over time and often by watching good examples.

Based on these findings I would propose that perhaps good engagement is a conversation. Of course, good conversations are not always positive, and unpicking the content and teasing out the issues has to occur, as is seeking and accepting the other person's perspective, and hearing their views. The need for authenticity when engaging is crucial – this emerged strongly, and this is solely dependent on the individual's style and self- belief in what they are intending to achieve from engagement. Organisations would do well to ensure that leaders hold the key skills to ensure engagement, including making the time for effective engagement. Lack of time was stressful and impacted upon the individual's self-satisfaction. Expressed as personal negative self-reflection by individuals, this, I suggest, demonstrates good insight and should be considered a strength of leadership.

- Smaller organisations appeared to be more closely connected to the people, but engagement and feedback is still a critical component to staff feeling respected and valued.
- The 'feel' of the internal culture should be given due consideration as it impacts upon effective relationships and thus clinical governance and patient outcomes.
- Good engagement is a conversation, whether positive or negative, towards reaching a position of understanding each individuals' view and should be encouraged to establish professional input and advice for improved governance.
- Feedback as a consistent process increases an individual's sense of worth and value -organisations should make this a priority as it appears to be the most important aspect to clinical governance function and relationship with the board and staff.
- Establishing mechanisms to appreciate what matters, why and how best to initiate structured engagement could be beneficial to clinical governance function.

The challenge for governance and management is how to take staff with you on this journey. Structures and processes established to support this communication can only be successful if leaders are competent in this area. Optimising effective governance requires access to expert counsel on clinical issues which includes the ability to recognise the value of the clinical contribution, the openness to accept that good governance means being willing to put aside preformed views and respect the *'weight of expertise*' that clinicians offer to boards.

So let us now consider the clinical governance committee as the ritual of recognition of the clinical governance function. All organisations mentioned their committee very early in the conversation. For some, it was a fleeting reference that seemed to 'get it out of the way' early on; for others it held weight and significance and appeared valued. If we recall, the committee was referred to during interviews in a variety of ways: outputs, such as the minutes for instance - '*evidence*' that the committee had met; relief that '*we got it finished';* uncertainty as to whether anyone actually read the said minutes after

circulation. Should one infer from the tone of the comment that either way might not matter? Frequency of meeting – "*clinical governance meets every two months*", and make-up of the committee "*it's mainly concerned with ward and hospital so involves mainly nursing and medical*". The discussion, however, would be incomplete until we consider other features that emerged of the 'committee'.

So, what else deserves discussion in relation to the committee? Firstly, no one actually said the meeting was a waste of time, although it was implied. The relationship with board appears to be a key influence as to whether it is a useful committee. Feedback from the board and engagement with the board clearly influences the level of enthusiasm of the committee activity. As I see it, the link here is the *overt* recognition (therefore respect) for the *professional voice*. The board that is active in discussing clinical issues, and interested in understanding implications of information are fulfilling their governance responsibilities. Governance could consider clinical governance as a due diligence function of governance and an essential risk reduction strategy. Connecting well with staff in a large organisation is challenging.

- The Committee is a significant and necessary part of good governance.
- Good governance sets the direction of travel for the organisation.
- Wise expert clinical contribution makes governing safer for the organisation and patients.
- Clinical staff value this input to the board.

Making sense of clinical governance

Insights for managers and leaders relate to the basic issue of language. Interviewees expressed clearly said information has to make sense to all. I can speak from personal experience - the higher you go up the career ladder the more impressive you need to sound and jargon becomes second nature. I can say that I left some interviews feeling as if I had experienced a tutorial on clinical governance - frameworks, plans, project processes, leadership steps, investigation processes and so on. The challenge for leaders and myself is how to translate this jargon into useful language and have it make sense to everyone. If we want to grow leaders we need to encourage participation in learning opportunities "*learning on the fly*", isn't good enough even though it implies that is the way organisation's learn.

My research also demonstrated that those in leadership experience doubt and feel they do not know all the answers. The finding that allied health in one organisation did not participate in the research "*because she didn't know enough about clinical governance*" is telling. As leaders, whether in management, governance or professional roles, we have an opportunity to share our knowledge to create better environments in which we practice.

Interview as an intervention

So what happens when an interview becomes an intervention? Why does this matter? One of the most rewarding findings in this research is that a conversation can be a change agent. The simple act of focusing on a topic and exploring what it means and what it feels like can alter the perspective of the participants. We as leaders or managers often resort to formal presentation and structures to impart and 'spoon feed' information to our audience. My interviews demonstrated that the straightforward action of holding a conversation could change the way individuals view a situation or subject. Conversations are, therefore, a change initiator.

- Leaders take responsibility for translating jargon into meaningful language.
- Leaders can also learn and don't know it all; if they think they do that's a problem.
- Clinical governance should not be exclusive – include all disciplines.
- Everyone has something to contribute to the quality discussion.

Leadership matters and is a significant contribution to effective clinical governance.

I have heard clearly that leaders are crucial in supporting good clinical governance. Leadership comes in many forms; traits needed to embed and sustain clinical governance should be a key consideration and include professional accountability, living the values, securing trust and demonstrating integrity. As pointed out in one interview once trust is broken it cannot be retrieved and so congruence of message and action, verbal and non-verbal, must be consistent. Leaders want to support staff, even when they make mistakes; this is one of the key principles of clinical governance. How the leaders support staff is what matters most - if they wish for staff to be fully engaged. Leaders might benefit from considering ways to create mutual understanding of clinical governance.

Leaders also need support. Leaders often struggle to lead clinical governance without adequate time or administration – and this is a disincentive for some. Leaders need to take time to understand the history (nature) of the organisation when trying to embed clinical governance activities; good leaders recognise the existence of sub cultures that have strong influence on success or failure of initiatives; engagement strategies need to be consistent – "*never a one off affair*".

So what does this mean for management?

- Choosing your leaders is a crucial decision.
- Ensuring leaders are supported to perform their roles will enable improved achievement of outcomes.
- Focus on accountability needs to be strong and systems to assess commitment to this should be part of leadership review.
- Leaders need to appreciate things that influence their culture.

Organisational culture

What gives the organisation heart? People. The culture of an organisation appears to hold significant influence in whether clinical governance is successful. Many tacit messages emerged in the interviews, often in the chatter between questions and in the 'what else'. Firstly, the way an organisation feels emerged; first impressions also influenced how I felt when greeted and so on. From the welcome, the sounds outside the room, the warmness of greeting and the openness and engagement with the interviewee. For some, the culture is assessed each time they come to work – it's the way the place feels, when you walk in, and that the staff are happy to come to work to do a good job. Every organisation referenced the people that deliver the care as being the heart of their organisation. No one said that leadership directly influenced this. The way leaders described staff might indicate the level of connectedness - for some it was "our staff', for others "they", and perhaps more importantly it was *how it was said.* So what ways to assess culture? Measures were helpful to some, but not for others. The purpose of measures emerged as a benchmark and a way to begin a conversation, and so the perennial theme of conversation and engagement is being reinforced. What emerged also was a sense of connection and pride for some more than others; most were clearly connected to the primary purpose of the organisation.

So what does this mean for managers and leaders? Promoting a culture that is ready to embrace clinical governance and engagement requires leadership that is insightful and reflects on authentic leadership traits and behaviors. Good leaders also understand the influencers on engagement and satisfaction and, what staff need in times of stress and how to maintain and grow relationships and connection. Understanding or seeking insight into what disengages staff might help direct organisational efforts towards understanding things that influence the culture. (E. Schein 2010) (May, Gilson, and Harter 2004)(Maslach 2001) The ability to influence and persuade others relies on forming mutually respectful relationships. Analysing the traits and incongruences that prevent this from occurring is a key responsibility of good governance.

Key points emerging from all interviews

- **I**t's about people – always the people.
- It's about those served in our community - the patients.
- The clinical governance committee is a seminal structure and should be the lynch pin that represents the professional collective voice.
- Clinical governance is part of the continuum of good governance.
- Working and trusting each other is important – better culture better outcomes.
- It's about being valued or valuing – nurturing the heart.

- It's about authentic and connected leadership – being sincere and consistent.
- Understanding and knowing your organisation mission and history is crucial.
- Strategy never featured once - it was all about culture, engagement and relationships.
- Ask what is your culture? What matters / what do you feel when you walk through the door?
- Words can disengage and slow progress – people need to feel they understand and are not fools.
- Don't assume staff understand – even senior staff.
- Insight is useful – gaining insight requires effort and inquiry.
- Framework, systems and process are the mechanisms to deliver activities of clinical governance but professional respect, courageous conversations and professional accountability bring it alive.

Focus groups

Three focus groups provided opportunities to validate my key findings. Initial plans to hold one large group was unsuccessful. All but one participant attended. I presented my findings verbally initially to see if the 'chat' resonated; this worked well with such small groups. Lots of active listening, nodding, questions. An enjoyable conversation. Resonance with engagement, values and the significance of the clinical governance committee emerged strongly. Discussion ensued for some, about the committee function, especially about the responsibilities for raising issues and time to get things prepared for committee. The relationship between clinicians and board led to particular interest and conversation about the generative model of governance, especially in the smaller organisations. There almost seemed to be relief for one organisation that finally there was 'information' supporting the role that clinical governance committee play in the governance continuum '*this is really good information…the first time we've had a chance to think about these issues…'* Organisational culture and '*how the place feels*' resonated strongly; body language such as nods, connecting with each other visually and murmurs accompanied this. There was absolute congruence with the need to create environments of high engagement and consistent communication as well as staff support. I also felt that by acknowledging that not everyone is trained or prepared for clinical governance affirmed that it was ok not to know the concept well - getting this out early seemed to visibly relax some individuals; especially those that I felt were very engaged in hearing what was being offered. Available time varied between organisations and this did affect the depth of conversation in one organisation where I felt it was a rapid delivery of information; however, I was able to leave my summary points for them as reflection when they had time. Perhaps one most intriguing discussion point was about defining good governance in health, and provoking thought as to whether clinical governance is the icing on the cake, or is in fact the cake itself?

In this chapter I reviewed the findings of clinical governance, organisational culture and leadership. Focus group sessions resonated strongly with the suggestions for improving engagement and governance discussion opportunities. The validation by participants of the findings add significantly to the usefulness of this research, especially related to the preparation of clinicians in clinical governance and the focus on values and culture. There was particular interest in the opportunities that introduction of 'generative' discussion could add to the decision-making processes and communication between clinician and board. The findings of the research are important for organisations to consider when working in this domain, and with leaders and clinicians. My research has also contributed a deeper understanding of how leadership and organisation's impact on individuals willingness to engage in clinical governance.

Chapter 7: Professional Practice Framework

As described in my motivation chapter there were three goals for undertaking this professional practice research. My intention was to understand what clinical governance meant to participants and explore any relationships between organisational culture and leadership. Having completed my work project to this point in time has enabled me to reconsider how I will work with organisations and colleagues. The approach offered is simple and encourages a level of inquiry by leaders. Those unwilling to consider simplicity as a starting point may continue to have differing success with clinical governance initiation and support. Based on my small study, I see that considering a different approach will create opportunity for enhancing not just clinical governance but longer term relationships that foster respect and collegiality and improve outcomes for service users.

The opportunity of adding insight (generative) to the foresight (strategic) and oversight (fiduciary) mechanisms of governance could improve decision making by engaging clinicians in meaningful contribution to boards. Consequently, clinicians may feel an improved sense of reciprocation and engagement. Leaders and governance should not underestimate the impact of power on behavior of staff. Relationships are complex, especially in smaller communities where the personal stakes are high, and so representation by board and management at clinical governance committees need careful consideration.

My research suggests that there are compelling reasons for leaders to consider new ways to approach clinical governance and increase engagement with staff and by staff. The supporting literature has added depth to appreciating the theory behind clinical governance history, rationale and definition. There is much written about the concept of clinical governance, including the systems organisations are required to implement to demonstrate "*everyone is engaged",* and that the system will "f*lourish*". Focused on the 'what' (systems, audit process…) and 'who' (all staff at every level), my question is why is it so difficult to get clinical governance embraced?

The richness of the research findings demonstrate the crucial role organisational culture plays in our work environment. Leaders may lead, but the key question I ask, is anyone following? Organisations need to reconsider what they know about how their staff experience their work, and what makes their work personally meaningful.

Attempting to address the 'symptoms' of non-engagement in this complex topic suggest that it is wiser to approach what is 'causing' the lack of engagement. One of the great aspects of being a health professional is seeing the patient outcomes – the difference we make to individual's lives at the beginning, during life, or at the end of life. For most health professionals this is the most rewarding component of practice. Organisations expect health professionals to perform to very high standards – technically, empathically and professionally. Rarely do we as leaders enquire to understand what the staff feel or what matters to them.

Leaders view the world through their lens as leader - what could change that lens and open them to explore improved ways of connecting with the staff? Waving a framework around is unlikely to achieve such connection. What we are good at as leaders is 'spraying and praying', meaning we send out

frameworks or policies that 'must be implemented' with little, if any, meaningful discussion. It is no way to engage intelligent people, and simply contributes to disconnection between governance, leadership and staff.

The opportunity for change is elementary, but is an approach to consider for organisations embarking on clinical governance. Taking time to understand how to engage staff meaningfully will enhance the work place culture, regardless of the required changes or project.

Conversations are powerful: Roberto says:

> "Great leaders do not simply know how to solve problems. They know how to find them. They can detect smoke, rather than simply trying to fight fires." (Roberto 2009).

I suggest that leaders ask themselves some personal questions, and then engage in conversations with individuals and groups. By conversation, we achieve connection. By connection, we discover commonalities and begin to get to the 'heart of the matter' as we uncover the hidden issues and problems that are covert.

Conversation starters and questions


Do staff feel respected?
How can I tell if staff feel respected?
What does respect and trust look like?
Does clinical governance mean anything to anyone?
How will we find out?
Is the committee respected and relating well to governance?
How do I know and why is this important?
How does governance feel about the Clinical governance committee?
Is our culture healthy? How do we know?

In this chapter, I review the findings of clinical governance, organisational culture and leadership. My research has also contributed to my practice framework as a practitioner and I have developed a deeper understanding of how leadership and organisational culture affects individual's willingness to engage in clinical governance.

Chapter 8: Reflective Summary

My learning contract proposed the development of a tool kit for clinical governance. Based on my new understanding of the issues that influence clinical governance, my original proposition is no longer such a useful idea. Indeed, there is so much resource and literature that it would be foolish to try to emulate existing resources. However, my significant contribution to clinical governance is in encouraging organisations to become inquisitive about the internal influencers that fully engage individuals within their work context. Clinical governance becomes part of the fabric of the organisation if staff engage and have clear purpose. Governance information improves because conversations are meaningful and therefore individuals are psychologically available participate fully. As the themes and nature of the narrative emerged, I was asking myself what would I want to explore in an organisation if I were introducing clinical governance? Where would I start, and what would I want to know? Analysing the interviews gave me those answers: literature helped me decipher what the challenges are, and where the solutions lay. I concluded that clinical governance could only flourish if organisational culture is ready to embrace it. Organisational culture '*is how the place feels when you walk in each day*'; how the place feels is based on being valued, trusted and supported, even when things go wrong; being valued, trusted and supported encourages meaningful engagement.

I often reflected on my observations of practice settings as I considered how to approach this point in the project. For me the essence of good culture is observing engaged clinicians go about their work - the flow and their focus, the synergy and the teamwork, the communication. This is when an organisation shines – at those times I do not imagine any individual considers whether they are flourishing, they are simply doing what they do best. Recognising how significant engagement is to the performance of an organisation leads me to approach my 'toolkit' as a discovery process for leaders.

My purpose is to uncover the 'what', 'where', 'how', and 'why'. For leaders this approach takes some personal courage; it means being personally aware of the psychological conditions that have been discussed in Kahn's model of engagement. Psychological safety, availability and meaningfulness apply as much to leaders as they do to others; self-assessment of this state of readiness is a good place from which to start engaging others. (Kahn 1990)

Leaders are more likely to be receptive to hearing other points of view if they are fully engaged in their role. Sharing views, being open to feedback, and offering genuine support is likely to result over time in reciprocity from others. Saks' antecedents to engagement identify that the perceived support of managers / leaders has an effect on willingness of staff to engage fully. (Saks 2006)

The best leaders seek out information; they go looking for problems, before they become disasters. (Roberto 2009)

Leaders need to lead – and starting at the beginning is a good place. How do leaders feel in thinking about this model's approach? What is their intuitive response to considering these questions? Will they enjoy the process of exploring these questions or will this cause discomfort? Do they feel secure in asking? Where would they start and with whom?

My experience in cultural change required a good deal of self-reflection as well as accepting that others saw me differently from my self-perception. Daunting as it was, sharing these findings as part of conversation opened doors for me to become more than a label – it created connection and implied trust that the wider team would respect my openness. For some it instilled confidence for them to follow the lead and assess themselves. The outcome was a change in team dynamics - staff were more open in sharing ideas, feedback offered freely, staff owned their view, defensiveness reduced, and chatting increased.

However, leaders cannot lead if they are unable to take people with them. This has two key needs - the leader is prepared to connect and the person connecting with is willing to respond. The challenge for many leaders is being able to find the moment that enables a start to the conversation. Recognising the moment that a relationship changes requires some reflection, and a degree of emotional intelligence to know it has occurred! Understanding their personal style and approach, and the affect they have on staff requires insight. Mature leaders reflect on their actions and outcomes, seek feedback, and welcome opportunities to re-think the way to approach situations. Leaders need to know the difference between an engaged staff member and a satisfied one. For leaders, often the hardest part is initiating the conversation. Once you begin, you are committed; it requires time, intention and being present, planning and being 'available' matters - if these conditions do not exist, the opportunity for engagement is likely lost. I do not think leaders would naturally associate the term reciprocity with engagement, and so thinking about this might be helpful. After all, if the relationship is to become a rewarding and mutually respectful exchange we need to recognise the contribution of the other. (Saks 2006)

> "The task is one of engaging hearts and minds which will require actions and words linked with an unusual level of coherence and consistency." (Davies, Nutley, and Mannion 2000)

Governance leadership might also ask itself some questions. Governance governs well when they receive information that assists with exploring constituent benefits and consequence. This requires trusting communication and the willingness to embrace collegial as opposed to congenial discussion. Leaders openness to debate is increasingly important as governance (clinical and corporate) contends with many facets to form good judgment. Governance and leadership need to invite conversation that generates collective understanding. I call this accountability. The historical approach of separation of management and governance left leaders responsible for the consequences of poor decisions. Governance being happy to listen to proposals and tick the box - it made governing easy. Good governance is not easy. Straddling the corporate world and clinical world sometimes creates a confluence of conflicting priorities. Navigating the relationship and boundaries between clinical and corporate governance is challenging. Historical working styles are well embedded - the perennial issue

of separation of governance and management, deference to power, leaders that 'rock the boat' become an irritation factor quite quickly creating reactive discourse and less willingness to engage. So, what is the answer? Introducing new ways of approach is not simple, but it is worthy of consideration. For instance, I would ask what purpose does having governance representation on the clinical governance committee serve. Whose agenda is it driving? What is the message to clinicians? If we are to be accountable, we should reduce the possibility of proposals being '*headed off at the pass*'. We should embrace the robustness of debate around the board table leading towards consequence thinking and decision making. (Carver 2013; E. H. Schein 2010) (Taylor, Ryan, and Chait 2013)

Reflection during study has deepened my learning experience. The most profound aspect is that this has been a self-directed discovery; what I have achieved is self-driven by my inquisitiveness and desire to know more. It has felt like a progressive, evolving piece of work that has changed shape as I have made other discoveries on the journey. I can now compare similarities with my practice environment whereby process and structure was a huge support, especially in the formative years, prior to becoming proficient in my practice when intuitive knowledge took the place of process.

The most precious learning has emerged through the conversations with my mentors. I generally enjoy interacting and engaging in conversations, many of these are, however, superficial and part of daily life and inevitably focused on the other person. In prior roles people have always come to me for mentorship and advice, and so the privilege of being a recipient has a lasting impact. The pleasure of mentorship is immersion in focused conversation that produces personal insight. Insight that invites me to consider a different point of view, think about my responses to a situation, have a non-judgmental conversation. Processing, spending time unpicking the discussion content to make sense of how this might help me re-frame my thinking comes later as I go about my day. During these 'chats', I am secretly admiring that my mentors are able to stay in the present – focused and not distracted by the other demands on their time. I hope they realise how important that is to students.

Using the appreciative inquiry method was a great frame for asking open-ended questions. I learnt quickly that questions lead to other questions. The richness of the narrative benefited from the flow and the gems came from asking 'what else'. My participant response to interviews added terrifically to the findings.

My internal discussion was about my role as researcher. It is strange to be novice at this point in life. I worked with Benner's model 'Novice to Expert' in my professional role early on; Benner (1982) describes novice:

> "If I say, you have to do these eight things, they do those things. They don't stop if another baby is screaming its head off. When they do realise that the other child needs attention, they're like mules between two piles of hay."

I am not sure I ever behaved like the mules - but I may have felt like the mules!

I drew comfort from Benner that this experience over time would change my approach to become competent as a qualitative researcher. In my approach to the first two interviews, I demonstrated

classic novice thinking - terribly focused for fear of doing it wrong! As I progressed, I recognised my confidence improving – it was after all a great conversation. I could look beyond the task and seek more information without going off script; my practitioner experience intuitively guided my competence ethically and practically, and I began to enjoy assimilating the whole picture emerging around me. Benner also helped me appreciate the meaning of phenomenology, this was helpful to my emergent framework of practice that required me to integrate of the role of researcher. I recognise at this time that the formative years in our career give us our foundation from which we become the person at whatever the point in time is. Nursing and management requires solid interview capability and so I feel it was the change in 'role' that worried me initially. As with developing new skill, the ability to become expert and work in the unconscious competence domain is some way off – but the foundation stone is now laid. (Cody and Mitchell 1996; Benner 1982)

Transcribing the narrative was a joy. It was hard work, time consuming and patience was needed. I could as part of this process, visualise the interview. I felt this was an important component of my understanding the analysis – it provided context and meaning to the pauses and comments, and the humor. The pauses possibly told the biggest story - I began to like pauses – profound thought usually followed a long pause. I could write an essay about pauses and outputs. One interview in particular had quite an impact on me – I now have an increased appreciation of the effect of conversation. This realisation challenged the way I had considered my 'toolkit'. I have since focused on conversation as the starter. Conversation in itself is a change agent. Without distraction of charts, diagrams and words, conversation allows connection, clarification and inquiry. When coming to this place in my approach I reflect on those that have influenced my desire to learn, and I remember those that connected; made it meaningful and applicable in my life. My project output should not be any different, and it would have been easy to stick to the original goal of fancy diagrams, but for what ends?

Immersion in the data was a phenomenal experience. Consuming and rewarding. The data had a profound effect on me. I enjoyed the immersion and then 'seeing' the connections and links as the findings unfolded. I experienced surprise, a few 'ah ha' moments, and a few deep sighs when the going got tough. It has changed my view of clinical governance forever. I felt very humbled as I read the transcripts – the openness and frankness.

Strengths and limitations in my project relate to design or outcome.

Strengths include the number and breadth of interviewees, organisations and model of service differences. This variety added opportunity to experience different perspectives and improved my overall appreciation of the findings. Participant's job roles gave breadth to the interview content, governance for instance contributed the big picture stewardship views, and clinicians offered pragmatic daily life views. Managers / executives offered the strategic /operational functional perspective. Working with not for profit and government funded provided deeper insight to my findings.

Limitations in my project are twofold. I was unable to access contribution from Māori. The overall impact of this has resulted in less than optimal information to help inform views or approaches. My practice framework changes are, therefore, limited to concluding that this area of study is worthy of further research.

My second limitation is the lack of opportunity to interview frontline staff. The scope of this project would have grown excessively had I increased my interview numbers. However, given that there is less literature discussing frontline staff perception of and participation in clinical governance this area is worthy of further research.

Overall, the project has become a major influencer in how I approach clinical governance. In my past practice, I was very familiar with the topic and I may have assumed others were also familiar. The option of formally considering how I would connect differently in my future practice required a good amount of introspection and finding out why this topic is so challenging to many. The outcome of this work project is satisfying and I hope it provides some insight to the organisations that participated.

In this chapter, I have reviewed my practice framework as a practitioner in clinical governance, and I have described my rationale and understanding of the impact leadership and organisational culture play in the clinical governance arena. I have incorporated my reflection of the study journey in completing the MPP and the change in my approach to my topic of study, and areas for further research.

Conclusion

In this thesis, I have described the dual development of a work project, exploring clinical governance, organisational culture and leadership in the context of my professional practice as a leader and manager. In this final chapter, I recap my contributions in the three initial areas outlined:

1. the articulation of the framework of practice
2. the change opportunities in practice associated with the framework
3. the impact of that change.

These conclusions were reached in the context of established literature and practice, and reflection on my personal learnings, and validation of my findings by focused follow up with participants.

My professional framework of practice is that of leadership, management and nursing. Leadership of quality is an intrinsic component of such roles, and my aim in completing this work was to develop a deeper understanding of the way clinical governance is understood by those participating in clinical and management practice, and to identify relationship between clinical governance, organisational culture and leadership. My application of this new knowledge serves two purposes: my intrinsic desire to answer these questions and gain new knowledge and understanding. My practice aim is to enable organisations to gain insight as to what makes clinical governance meaningful to their staff. I have also considered clinical governance in the context of good governance and explored ways that clinicians and governance might consider enhancing decision-making and create improved collegiality and accountability. During completion of this work I have read widely and attempted to identify literature that support my findings and, as well, I have also identified deficits in literature, or alternative courses of theory that contradict aspects of the philosophical basis of good governance. I have noted the evolving

changes that occurred throughout this project, and I have commented on the strengths and limitations of my study.

My conclusive comments are an amalgam of the analysis of rich informative narrative. Perhaps an overarching comment is that, for me, this topic is far from complete as far as understanding the wider workforce views, including Māori. There is opportunity for further exploration of many aspects of this study; literature focusses very much on the systems, process and definition. It does not, however, elaborate the 'how' leaders might facilitate engagement of staff in this complex and necessary concept.

In summing up my findings, I offer that clinical governance is the intersection where the collective clinical and corporate governance voices meet. The surprise for me is that the conversations about the quality systems took a back seat once the conversation shifted to organisational culture and leadership. Perhaps my question should have been 'does values based leadership, and engaged staff result in improved clinical governance culture? In a nutshell, that is essentially what the findings indicate, and then I would have not had much to write about.

So, in a nutshell, organisational culture based on values reflecting respect, trust, support and accountability matter if clinical governance is to be embraced. The most important activity for leaders is to create meaningful connection and engagement with staff. Providing feedback is important, and staff are more likely to disengage if they do not get feedback.

The role of the clinical governance committee emerged as more significant than I had imagined; I describe it as pivotal in legitimising the link between practice and governance. I have offered some comment highlighting opportunities for reconsidering who sits on the clinical governance committee – sometimes best intentions have unexpected consequences and whilst governance support is considered helpful, it is can also stymie some ideas before they get a chance to be debated.

Frameworks, are only helpful if it makes sense to staff. People are what brings clinical governance to life.

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Appendices

Appendix A : Consent form – Phase One – Individual Interview

Consent form – Phase Two – Focus Group

Appendix B : Information for Participants

Appendix C : Kaitohutohu Consultation Feedback

Appendix D : Interview Questions

Appendix E : Data Analysis example

Appendix F Data Analysis example

Appendix A

CONSENT FORM

PHASE ONE –INDIVIDUAL INTERVIEW

CLINICAL GOVERNANCE ORGANISATIONAL CULTURE AND LEADERSHIP

I have read the information sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

* My participation in the project is entirely voluntary.

* I am free to withdraw at any time prior to approving my transcript without giving any reason. Once I have approved my transcript my information will be anonymised and it will not be possible to remove the anonymised material.

* I agree to allow use of quotes that have been anonymised from my approved transcript.

* The audio recordings and interview data will be destroyed at the conclusion of the project unless specific permission is requested for aspects of my information to be retained for a specific purpose.

* I will be offered a copy of the draft summary report for my personal viewing which will provide me with an opportunity to propose changes.

* Any resource or education information on which the results of the project depend will be retained in secure storage for up to five years after which it will be destroyed. If it is to be kept longer than five years my permission will be sought.

* My time is offered free from compensation or remuneration

* I acknowledge that one of the project outcomes is a practice framework and toolbox for education purposes; as such I acknowledge that information gathered will be used without identification of source to inform development of resources for education purposes.

MPP T Bradfield Student 1000059878 /157224653
Clinical Governance Organisational Culture Leadership
Consent Form Phase One Individual Interview
8 September 2019

CONSENT FORM

PHASE ONE –INDIVIDUAL INTERVIEW

CLINICAL GOVERNANCE ORGANISATIONAL CULTURE AND LEADERSHIP

* I acknowledge the final research report will be confidential to the student and supervisors of the Master's program.

* I acknowledge that following completion of the research report and resources occasional presentations may refer to the process of gathering the information but details of specific contribution will remain generic.

* I acknowledge I have permission to participate in this research project from my employer

I agree to take part in phase one of this project based on the conditions set out in the Information Sheet.

..... Signature of participant

.....Date

..... Signature of researcher

This project has been reviewed and approved by the Otago Polytechnic Research Ethics Committee. Category B Delegated Authority. Contact Dr Glenys Forsyth for further information (glenysf@op.ac.nz 021 0549 233)

MPP T Bradfield Student 1000059878 /157224653
Clinical Governance Organisational Culture Leadership
Consent Form Phase One Individual Interview
8 September 2019

CONSENT FORM

PHASE TWO – FOCUS GROUP

CLINICAL GOVERNANCE ORGANISATIONAL CULTURE AND LEADERSHIP

I have read the information sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

* My participation in the project is entirely voluntary.

* I am free to withdraw at any time prior to approving my transcript without giving any reason. Once I have approved my transcript my information will be anonymised and it will not be possible to remove the anonymised material.

* I agree to allow use of quotes that have been anonymised from my approved transcript.

* The audio recordings and interview data will be destroyed at the conclusion of the project unless specific permission is requested for aspects of my information to be retained for a specific purpose.

* I will be offered a copy of the draft summary report for my personal viewing which will provide me with an opportunity to propose changes.

* Any resource or education information on which the results of the project depend will be retained in secure storage for up to five years after which it will be destroyed. If it is to be kept longer than five years my permission will be sought.

* My time is offered free from compensation or remuneration

CONSENT FORM

PHASE TWO – FOCUS GROUP

CLINICAL GOVERNANCE ORGANISATIONAL CULTURE AND LEADERSHIP

* I acknowledge that one of the project outcomes is a practice framework and toolbox for education purposes; as such I acknowledge that information gathered will be used without identification of source to inform development of resources for education purposes.

* I acknowledge the final research report will be confidential to the student and supervisors of the Master's program.

* I acknowledge that following completion of the research report and resources occasional presentations may refer to the process of gathering the information but details of specific contribution will remain generic.

* I acknowledge I have permission to participate in this research project from my employer

I agree to take part in this project phase two based on the conditions set out in the Information Sheet.

..... Signature of participant

.....Date

..... Signature of researcher

This project has been reviewed and approved by the Otago Polytechnic Research Ethics Committee. Category B Delegated Authority. Contact Dr Glenys Forsyth for further information (glenysf@op.ac.nz 021 0549 233)

Appendix B

CLINICAL GOVERNANCE, ORGANISATIONAL CULTURE AND LEADERSHIP

MASTER PROFESSIONAL PRACTICE

RESEARCH PROJECT INFORMATION

My research project seeks to explore any relational links between leadership, organisational culture and effective clinical governance.

Clinical Governance is an accepted term for the systems that focus on delivery of safe healthcare to patients by reducing harm. External drivers include regulatory bodies, political drivers, consumer demands and legislation. Internal drivers for creating a culture of good clinical governance vary across the sector; little is written on internal influencers and yet it is suggested that for successful and committed clinical governance this aspect matters. My research is focussed on understanding more about what matters in regard to internal influences such as leadership, organisational culture health, and whether this impacts on effective and sustained clinical governance.

The question:

'in what way do staff describe clinical governance *and* is there any relationship between leadership, organisational culture and effective clinical governance?'

Your participation will contribute to a collation of themes and elements that will inform my research report and framework.

How the research will be conducted?

Interviews

I aim to conduct individual interviews for the first phase of information gathering.
Interviews will be approximately I hour duration but may stretch to 1.5 hours.
The interviews are semi structured and will be audio recorded.

Focus Group

You will be invited to attend a follow up focus group. This meeting will be planned well in advance to allow for schedules. Please allow up to 2 hours for this meeting.

CLINICAL GOVERNANCE, ORGANISATIONAL CULTURE AND LEADERSHIP

MASTER PROFESSIONAL PRACTICE

RESEARCH PROJECT INFORMATION

The research project will be formally supervised by Otago Polytechnic

Consent process

You will need to complete an informed consent form. The consent form details the way your information will be protected.

Other Things to consider

Your participation is voluntary

You must be either a Registered Nurse or Medical Practitioner, A Chief Executive or equivalent, a Governing Board Director or equivalent.

Your information will be kept safe as described in the consent form.

The research is formally supervised and has been approved by the Otago Polytechnic Ethics Committee.

The research receives research cultural advice via Kaitohutohu at Otago Polytechnic

Reports (final) are solely for the purpose of the qualification awarded

Questions

Contact

Student / Researcher :Teresa Bradfield Bradtm1@student.op.ac.nz

Academic Facilitator: Trish Franklin Trish.Franklin@op.ac.nz

Research Supervisor: Margy Jean Malcolm Margaret.Malcolm@op.ac.nz

Appendix C

Whāia te pae tawhiti kia tata whāia to pae kiā maua
Pursue the distant horizons so that they may become your reality

Office of the Kaitohutohu Research Consultation Feedback
Date: 19 October 2018
Researcher name: Teresa Bradfield
Department: Capable NZ Master of Professional Practice
Project title: Clinical Governance Organizational Culture and Leadership

INDIGENOUS INNOVATION: Contributing to Māori Economic Growth	
TAIAO: Achieving Environmental Sustainability through Iwi & Hapū Relationships with the Whenua & Moana	
MĀTAURAKA MĀORI: Exploring Indigenous Knowledge	This research project aims to broaden the knowledge base of the research within clinical governance. Links between clinical governance and operational leadership is an important issue for Māori organisations and Māori users of these services, with cultural safety being a priority for Māori and Government organisations. After discussion with the applicant, it became obvious that an insight into Māori clinical governance would provide the opportunity for the researcher to explore synergies and differences between Māori and non-Māori governance. An opportunity may exist with Te Kāika, a local Māori health and social provider. The applicant is encouraged and supported by the KTO office to make contact with this organisation and if engagement works for both parties, to collate ethnicity data so that comparative summaries can be drawn. The General Manager for Te Kāika is Shelley Kapua, and can be contacted on 03 4719 960. The applicant is encouraged to seek further engagement with the KTO office when considering and writing the concluding summary (if Te Kāika comes on board with this project). We wish you all the best in your research.
HAUORA / ORANGA: Improving Health & Social Wellbeing	
TO LIVE AS MĀORI: Kaitiaki to Ensure Māori Culture and Language Flourish	

UNLOCKING THE INNOVATION POTENTIAL OF MĀORI KNOWLEDGE, RESOURCES & PEOPLE

Name: Kelli Te Maihāroa
Position: Tumuaki: Rakahau Māori | Director of Māori Research, Otago Polytechnic

Interview Questions

Appendix D

QUESTIONS

Q Thank you for participating in my research – the focus is on clinical governance, leadership and organisational culture. Clinical Governance is an encompassing term. What does it mean for you?

Q Obviously, in any organisation there are highs and lows –but for today, I want you to start by focusing on a high point – a time when everything worked well from a clinical governance perspective. Can you tell me the story? How did it unfold? What was it that made this story stand out as a leader? Why was it so significant?

Q What key insights arise for you about what contributed towards a positive outcome in that scenario? What do you think were key success factors? What could have made it even more successful? What barriers prevent those improvements?

Q Would you have any suggestions for improving organisational understanding and practice of clinical governance? What would be helpful from your perspective?

Q What pearls of wisdom would you offer other leaders immersed in leadership and clinical governance?

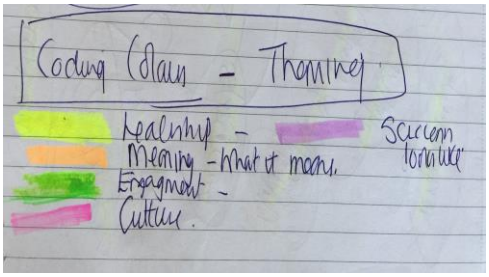
Q What do you feel gives life to your organisations culture of clinical governance and enables it to function at its best? What does successful organisational culture look like from your perspective?

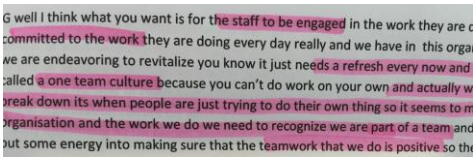
Q What insights might you offer about the relationship between organisational culture and sustainable clinical governance process?

Q Conclusion of questions. “What else might you like offer before we finish?

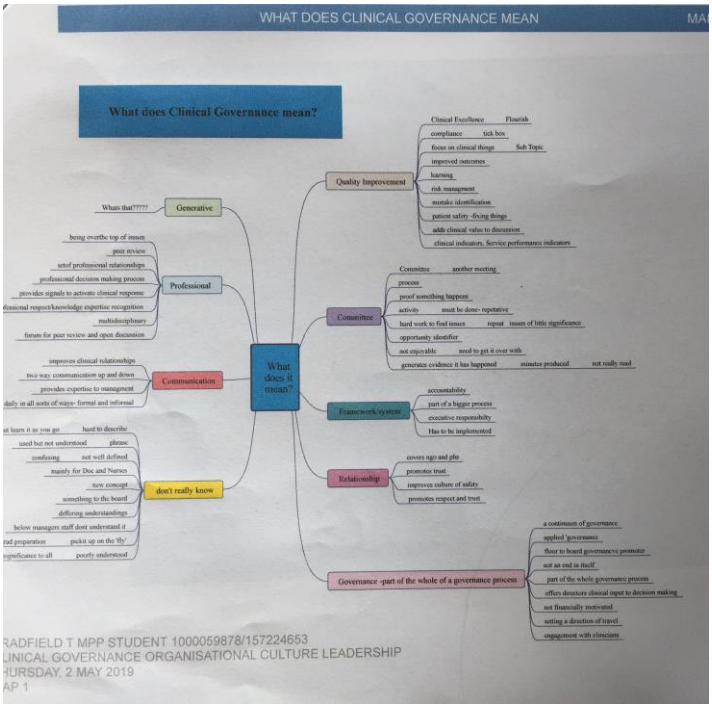
Data Analysis Examples

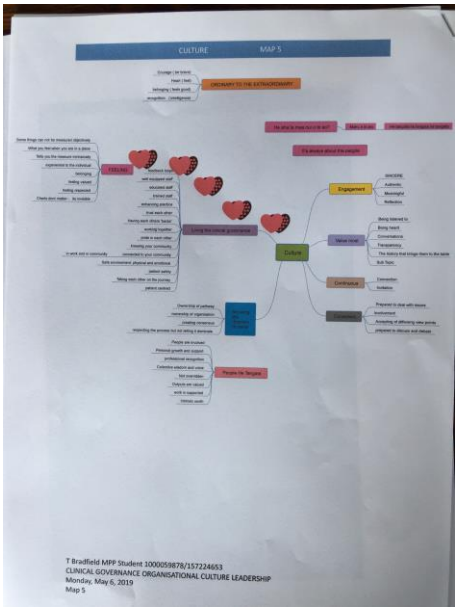
Appendix E





Appendix F


WHAT DOES CLINICAL GOVERNANCE MEAN
What does Clinical Governance mean?
What does it mean?
Generative
Whats that?????
Professional
being overthe top of issues
peer review
setof professional relationships
professional decision making process
provides signals to activate clinical response
multidisciplinary
forum for peer review and open discussion
Communication
improves clinical relationships
two way communication up and down
provides expertise to management
don't really know
hard to describe
used but not understood
phrase
confusing
not well defined
mainly for Doc and Nurses
new concept
something to the board
differing understandings
below managers staff dont understand it
poorly understood
Quality Improvement
Clinical Excellence
Flourish
compliance
tick box
focus on clinical things
Sub Topic
improved outcomes
learning
risk management
mistake identification
patient safety -fixing things
adds clinical value to discussion
clinical indicators, Service performance indicators
Committee
another meeting
procesn
proof something happens
activity
must be done- repetative
hard work to find issues
repeat
issues of little significance
opportunity identifier
not enjoyable
need to get it over with
generates evidence it has happened
minutes produced
not really read
Framework/system
accountabilty
part of a bigger process
executive responsibilty
Has to be implemented
Relationship
covers ngo and pho
promotes trust
improves culture of safety
promotes respect and trust
Governance -part of the whole of a governance process
a continuum of governance
applied 'governance
floor to board governance promoter
not an end in itself
part of the whole governance process
offers directors clinical input to decision making
not financially motivated
setting a direction of travel
engagement with clinicians
RADFIELD T MPP STUDENT 1000059878/157224653
LINICAL GOVERNANCE ORGANISATIONAL CULTURE LEADERSHIP
HURSDAY, 2 MAY 2019
AP 1


CULTURE
MAP 5
ORDINARY TO THE EXTRAORDINARY
FEELING
Engagement
Value-Add
Continuous
Connection
Curious
T Bradfield MPP Student 1000059878/157224653
CLINICAL GOVERNANCE ORGANISATIONAL CULTURE LEADERSHIP
Monday, May 6, 2019
Map 5