Strengthening clinical governance through cultivating the line management role

Cathy Balding

Abstract

The implementation of clinical governance in health care services introduces increased responsibility and transparency around safety and quality into all staff roles. Encouraging staff to assume these responsibilities as part of their daily routine is fundamental to achieving effective clinical governance, and requires health care managers at all levels to embrace clinical governance leadership and management. Fostering this role will need to be approached skilfully if managers are to achieve effective leadership of clinical governance activities. This paper reviews the management and quality-related literature to explore how these roles may best be developed to ensure that health care managers are equipped and willing to undertake the critical task of translating clinical governance policy into day-to-day practice.

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What is known about the topic?

The concept of clinical governance as an essential contributor to the quality and safety of health care has been widely endorsed. The majority of current clinical governance literature explores the origins and background of changes emanating from clinical governance, the elements of clinical governance programs, and structures and frameworks to assist in its implementation.

What does this paper add?

This paper argues that clinical governance programs are unlikely to meet their obligations or achieve their potential if the principles are not embedded into every-day processes, with line management commitment to translating policy into practice. This requires systematic attention to the capacity of line managers, provision of the resources and support they need to be effective in this role, and consistent application of incentives and accountability requirements.

What are the implications?

Top-down leadership is essential, but will only work if it is enacted in a way which empowers clinical and non-clinical managers to build accountability for safety and quality improvement more effectively into their organisational structures and routines.

THE SUCCESSFUL IMPLEMENTATION of clinical governance in Australian health services necessitates changes in the roles health care managers and practitioners play in ensuring the safety and quality of their services. A key tenet of this change is more structured and visible delegation and enacting of accountability for safety and quality improvement at all levels of health care organisations. The way in which managers, and clinical managers in particular, understand, enact and implement these responsibilities is a key determinant of an effective clinical governance program. Crafting and assigning these accountabilities in a meaningful and sustainable way requires recognition of the essential role of managers at all levels of the organisation in embedding the program in day-to-day care and service provision. It also requires skill and commitment from chief executive officers (CEOs) and senior managers to cultivate and support line managers to take on this function.

Cathy Balding, PhD, Manager

Victorian Quality Council, Melbourne, VIC.

Correspondence: Dr Cathy Balding, Victorian Quality Council, Level 7, 589 Collins St, Melbourne, VIC 3000.
Cathy.Balding@dhs.vic.gov.au

From quality improvement to clinical governance

There is a long history of quality improvement programs in Australian health care organisations. Even before the Australian Council on Healthcare Standards (ACHS) made organisation-wide quality programs a formal requirement for accreditation in 1986, many health services had developed some

form of quality program, variously motivated by state government initiatives, clinically-driven audit programs and individual improvement champions. Health care professionals are trained to review their care and practise participation in improvement activities as a professional obligation, although this can play out as an individual pursuit rather than as involvement in organisational and systems-based activities.[1] The importance of these programs has been emphasised over the past decade via growing community and health professional concerns about the safety of health care, prompted in large part by information emanating from the Quality in Australian Health Care Study (QAHCS) in 1995, which described for the first time the extent of adverse events in Australian hospitals.[2]

The effectiveness and credibility of health care quality programs still varies considerably, however, and involvement in improvement activities is viewed as optional by some personnel. There are many reasons for this, with one key barrier to success being failure by the governing body, CEO and executive staff to give priority to defining and supporting clear organisational roles and responsibilities for monitoring and improving safety and quality.[3] Paradoxically, it has also been argued that, since the QAHCS, improvement programs have been promulgated primarily through a top-down approach, and that more of a bottom-up approach is needed.[4]

This is where effective clinical governance has the potential to transform traditional quality programs, by underpinning them with an accountability framework emanating from the governing body that provides a more systematic approach to leading and managing safety and quality. Staff buy-in at all levels of the organisation forms the basis of clinical governance, with the legal obligation for governing bodies to enact clinical governance driving organisational responsibilities that are no longer viewed as discretionary.[5,6] These accountabilities should encompass both individual roles in providing safe and high quality care, and individual and team roles in safety and quality review and improvement activities. CEOs and senior managers from the top one hundred performing hospitals in the United States noted that their achievements in improving clinical outcomes (that is, fewer complications and mortalities, better financial performance and treating an increased number of patients) arose from a strong commitment to improving safety and quality. These organisations established rigorous safety and quality systems, within which staff at all levels played a role, and the board assigned the same level of importance to clinical governance as it did to financial and other corporate matters.[7]

Inquiries into care provision in Australian health services over the past decade, such as the Royal Melbourne Hospital, King Edward Memorial Hospital and Macarthur Health Service Inquiries, have provided impetus for the development of governance frameworks to underpin and strengthen Australian quality improvement programs. A consistent theme in the findings from these inquiries is a lack of clear lines of accountability for, and reporting on, the quality and safety of the services provided, allowing poor practice to continue over the long term, resulting in negative and sometimes catastrophic outcomes for patients.[8] The concept of clinical governance emerged, initially in the United Kingdom in the late 1990s, in response to similar findings from the Bristol Royal Infirmary Inquiry, in an attempt to ensure that both organisational and individual accountability for safe and high quality health care was clearly defined and enacted.[5,8]

The accountability aspect of a safety and quality program underpinned by clinical governance is reflected in Australia in the ACHS definition: "clinical governance is the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care".[9] (page 4) Clinical governance emphasises the importance of governing clinical safety and quality with the same rigour as applies to corporate governance. This requires governing bodies to ensure that they have the same knowledge of quality matters as they do of financial matters, that the CEO and senior managers have in place a planned and systematic organisational approach to monitoring, managing and improving safety and quality, and that this includes clear delineation of and support for corresponding staff accountability and responsibility throughout the organisation.

Depending on the organisational role, this will include responsibility for quality improvement activities (eg, evidence-based practice, clinical outcomes improvement, systems review) and ensuring safety (eg, identifying, monitoring and managing error and risk) and may also cover specific involvement in major change and innovation.[10]

Leading and promulgating the line management role in clinical governance

Quality improvement has long been perceived by staff as "the top telling the middle what to do at the bottom",[11] (page 1978) which is a far cry from the empowered and participative model required to fulfil the intent and requirements of clinical governance. A recent review of the empirical research into the role of leadership in quality improvement programs reinforced that leadership is a fundamental component of effective safety and quality improvement with senior and line managers, informal and opinion leaders all required to contribute through translating clinical governance policy and plans into practice. The evidence is not scientifically strong, due to a dearth of controlled experimental studies in this area. However, the available studies demonstrate that leadership does have a positive or negative impact on the effectiveness of improvement programs, depending on the position taken by senior management.[3,12]

Achieving effective clinical governance requires a collaborative effort between CEOs, executive and middle managers, and clinical managers.[10] It is up to CEOs and senior managers to facilitate this collaboration. Clinician leadership, in particular, has been found to be a key success factor for improvement programs, but is rarely formally established without senior leaders endorsing and shaping organisational roles and processes to facilitate their involvement.[10,11,12] The empirical evidence supports the accountability requirements of clinical governance, in that it shows that senior leaders can best develop and support effective improvement programs by building a system of leadership for improvement across the organisation which supports improvement as part of every-day work.[3,12,13]

Getting started

The literature suggests that it is common for senior health care leaders to begin safety and quality leadership delegation via a process of education and training for line managers, but, while important, this is not sufficient in isolation. Line managers are "the connection between the vision of the top and the reality of those on the front line of business",[14] (page 9) but they may require encouragement and support to connect their staff with the clinical governance vision. Clinical managers, in particular, may require the input and encouragement of their peers both from within and outside the organisation, and are likely to be influenced by the example of their colleagues when deciding their level of involvement.[3] They will also need to be involved in and understand the strategic direction of the health service so that they can contextualise their clinical governance role and that of their department or unit. Informal and opinion leaders should also be identified and involved in these discussions.[10,12,13] From this point, the roles and behaviours required throughout the organisation to mainstream clinical governance can be identified and embedded in position descriptions and performance reviews.

The power of senior managers defining the relationship between the strategic direction of the organisation and a safety and quality improvement program has been demonstrated in a number of studies.[3,10,13,15,16] This appears consistent across all industries, including health care. CEO and senior management leadership in setting strategic direction, providing a viable vision and goals and supporting behaviours which encourage achievement of these goals, consistently produces the most effective, sustainable and mainstreamed improvement programs.[16] This is the first step to developing improvement programs that are driven by staff who know and understand the organisation's vision, are empowered and willing to align their actions accordingly, and take innovative and creative steps to achieve the goals they are asked to support.[17,18] This salient step also requires some homework on the senior manager's part to ensure they are equipped with the clinical governance knowledge and understanding to effectively lead the program.[12]

Key senior manager actions for enacting clinical governance leadership

Leading the management aspect of a clinical governance program can be played out in a number of ways with the literature advocating a number of key strategies:

- Defining the organisation's vision and values for safety and quality from the patient and staff perspectives
- Defining the strategic direction consistent with achieving the vision and values
- Collaborating with staff to identify the implications of the strategic direction for the clinical governance program, forming clear, achievable goals, and resourcing plans, roles and processes that will support the program
- Supporting managers and staff throughout the organisation to effectively carry out processes which contribute to safe and high quality care
- Equipping and empowering staff with the information, skills and resources to fulfill their responsibilities
- Facilitating and rewarding a collaborative approach to safety and quality improvement between clinical and non-clinical managers and their teams
- Elevating the status of safety and quality leadership in the organisation
- Removing perverse incentives and increasing incentives that reward engagement
- Modelling commitment to safety and quality through knowledge and participation
- Embedding improvements in organisational policy and procedures.[3,5,6,17,18]

Cynicism develops easily in the rigid organisational hierarchies that are health care organisations, and senior and line managers will need to be realistic about the potential disparity between the espoused ideals of the program and how they work in practice. The principles underpinning the clinical governance program will also have inbuilt tensions that require careful balance between sometimes conflicting demands, for example, celebrating success while tolerating and learning from mistakes.[19] Clinical managers, in particular, may struggle with these apparent contradictions, which contribute to traditional difficulties in building a culture of improvement. Values such as "tolerance of mistakes", "openness" and "trust" have not traditionally been incorporated into the professional training and hierarchies that dominate health care, and the relationship between a "just" culture and personal accountability is one that the health care community is still coming to terms with.[20] Involving line managers in clinical governance planning can assist in breaking down this cynicism and gaining commitment.

Fostering ownership of clinical governance roles

While senior management lays the foundation and framework for the clinical governance program, it is the line managers and staff who must implement this process by working together within teams and across departments. Senior management's directives are not able to be fully implemented without middle managers being enabled to design systems, change their practices and redirect their staff activities accordingly.[16] Clinical managers, in particular, play a critical role in the improvement of clinical practice, due to their input into clinical decision-making, day-to-day care processes and how the patient is treated at the bedside.[11] Managers' clinical governance responsibilities may include:

- Espousing and enacting commitment to clinical governance by their attitude to, and involvement in, safety and quality issues
- Translating the organisational vision and policy into meaningful application
- Seeking education and information to equip themselves and their staff to lead the safety and quality program
- Participating in the development and evaluation of a safety and quality plan and process which involves consumers and clinical and opinion leaders, to monitor and improve safety and quality
- Empowering and holding accountable staff at all levels to be appropriately involved in monitoring and improving care and services
- Establishing processes to review the ability of individual staff and teams to provide safe and high quality care

- Collecting, reporting and benchmarking valid, reliable and relevant safety and quality data
- Fostering a climate which does not blame, but rather seeks to solve problems
- Developing a multidisciplinary team approach to safety and quality that endorses working across organisational boundaries in the best interests of patient care
- Acting on recommendations where problems with quality are apparent via events or data monitoring
- Providing data and information to senior management, the peak quality committee and board relevant to their role.[19,21]

Involvement in planning

Early participation in planning and decision-making motivates ongoing management involvement at all levels. It can help detect and resolve real and perceived differences in definitions, values and perceptions around the purpose of the proposed program, and clarify the benefits of the new way of doing things for managers and staff. It is also important that the clinical governance program is planned to maximise the chance of successful implementation within individual organisational structures and constraints.[17,19,21-24] The value that middle managers, in particular, place on clinical governance will significantly affect its implementation. Goals that are not seen to be progressing the work and values of middle managers are unlikely to be communicated to staff in a positive and constructive way.

The core professional values of senior and middle managers around patient care are unlikely to differ significantly, but may be perceived as separate due to disparate preconceptions and labels, thus creating misunderstanding and division. These differences can be caused by the diverse language used at different levels of the organisation, described by Juran as the language of money used by upper management and the language of things used by staff. Juran observes the need for middle managers, in particular, to be "bilingual" in order to translate between organisational levels, particularly in the implementation of improvement activities.[25] In the quality-related literature, a commonly expressed belief is that most people who work in health care are intrinsically motivated to do a good job, with "the desire to help people by offering a high standard of service in a timely and courteous manner" (page 1978) the main motivation of clinicians.[11] Health care professionals of all backgrounds share this strong commitment to high standards of patient care, and are correspondingly demotivated by working with processes and systems they do not control and which do not address these values.[10,17,22-24]

A powerful tool for motivating Australian managers, in particular, to participate in change is to provide them with a strong reason, or cause, for their involvement. A "cause" for Australian managers is not necessarily being the biggest, the best or the most profitable. It is a call to something with desirable social, moral, national or community implications. Building and maintaining relationships is a similarly important motivator, and any change program that is seen to be threatening or deconstructing positive organisational relationships is unlikely to be supported.[13,26] Managers are more likely to embrace a clinical governance role if the goals and activities clearly demonstrate improvements for patients and staff, and provide a platform for innovative problem solving and service development.[1]

A collaborative approach to planning the goals and rollout of the clinical governance program affords managers at all levels the opportunity to explore these issues, develop a common understanding of why and how clinical governance should be implemented and to clarify role expectations. This lays the foundation for ongoing commitment and involvement at all levels, and may assist in addressing some of the scepticism that will accompany the move towards clinical governance. Maintenance of this commitment will depend on the action that follows the planning.

Empowering managers to enact their role

A central obligation for CEOs and senior managers is to create opportunities and enablers for all managers to redesign the work of their departments to achieve safer, higher quality care. Employee empowerment "forms the backbone of CQI" [27] (page 146) and such empowerment ideally includes the opportunity to seek and receive infor-

mation and feedback where necessary to perform these tasks, regular performance review with senior management, and clear delegation of authority for decision-making.[14,27] Empowerment can be confused with involvement, but requires more than giving people the opportunity to make suggestions, provide input and carry out actions. Empowerment means that employees exercise real decision making in redesigning and improving care, including prioritising changes, staff training and budget allocation. The development of clear and agreed boundaries and priorities, communication processes and physical resources to support such empowerment is a necessary and measurable element of senior management commitment to an effective clinical governance program.[3,27,28]

Not all middle managers will be enthusiastic pioneers of clinical governance, of course, and precise minimum requirements, supported by organisational structures and processes, are required to clarify the expectation that all staff have a responsibility to be involved in some capacity. Employees may be ambivalent about empowerment, particularly as related to improvement activities, as increasing responsibility can easily be seen as a not-so-subtle approach to increasing workload. Managers can be hesitant to engage in true empowerment because they may lose the security and control of a predictable role, and may have to accept greater responsibility and accountability if all does not go according to plan.[28,29] These potential pitfalls emphasise the need for managers at all levels to keep communication lines open about these issues, for individual accountabilities to be clearly stated, and consistently supported, and for the clinical governance objectives and processes to be transparent and achievable.

Strengthening the manager's clinical governance role through education

Training and education is consistently identified in the literature as a key element of successful improvement programs, and will assist in empowering and equipping staff involvement. Staff resistance to involvement in new initiatives such as clinical governance is often due to a perceived lack of skills to effectively participate, and it is unlikely that either managers or staff will embrace new responsibilities if they do not feel equipped to fulfill them. The provision of resources for training demonstrates highly visible and practical leadership commitment to enabling staff to be usefully involved. Provision of resources to backfill staff is also salient to the acceptance of the training, as without this, attendance may be both limited and resented.[15,21] Generic training to equip managers to lead clinical governance, depending on their role, may include:

- Leadership practice in the health care environment
- Quality improvement tools and techniques
- Managing risk, error and human factors
- Working with consumers to improve care and services
- A team approach to care — working across professional and organisational boundaries
- Effective communication and delegation
- A systems approach to improvement
- Managing change and implementation.[15,18,21]

Such education is unlikely to lead to positive changes in behaviour, however, unless underpinned by senior management support and organisational processes.

Conclusion

Clinical governance increases the scope of responsibility for the provision of safe and high quality care across health care services. Encouraging staff to take on these responsibilities as part of their daily routine requires managers at all levels to embrace a clinical governance leadership role — a "leadership system for improvement".[3] (page 110) Fostering these roles is challenging for CEOs and senior managers, and critical to fulfilling the obligations of clinical governance through the provision of measurably safe, high quality care. This paper has discussed some of the keys to motivating and enabling managers to fully participate, such as linking the clinical governance program to the strategic plan, collaborative development of plans based on shared values, clearly defining roles and responsibilities and providing support and training. Clinical governance is both a legal responsibil-

ity and core health care business. Realisation of the potential of these programs will depend to a large extent on the ability and willingness of health care managers at all levels to work together to embed clinical governance principles and practices in every-day care and services.

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Competing interests

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