An exploration of the roles and experiences of governance officers in an NHS trust

AN EXPLORATION OF THE ROLES AND EXPERIENCES OF GOVERNANCE OFFICERS IN ENSURING ACCOUNTABILITY IN AN NHS TRUST

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This work or any part thereof has not been previously presented in any form to the university or to any other body whether for the purposes of assessment, publication or any other purpose (unless otherwise indicated). Save for any express acknowledgements, references and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person.

Signed: …T.J. Ahme……Date: 10th Sept 2021

Dedication

To

GOD ALMIGHTY, for His Faithfulness.

To the memory of

Dr Vinette Cross
My Director of Studies
(2014–2017)

for her steadfast support and inspiration.

I slept and dreamt that life was Beauty
I woke and found that life was Duty
Was thy dream then a shadowy lie?
Toil on, sad heart, courageously
And thou shalt find thy dream to be
A noonday light and truth to thee.
– Ellen Sturgis Hooper.

Also, to the memory of

Dr Pauline Fuller
for inspiring me to do a PhD in 2005,
supporting me and showing keen interest in my progress.

Abstract

Background

Accountability is a key issue in the UK National Health Service (NHS). Clinical governance officers are a relatively new group of staff that are employed to help ensure accountability at the local level of the NHS.

Aim

This thesis explores the role of governance officers in an NHS Trust. It examines how they negotiate the space between managers and clinicians to ensure accountability.

Method

Using a phenomenological approach, semi-structured interviews and a focus group were conducted to explore lived experiences and views of governance officers. The study draws on theoretical frameworks relating to role theory, Foucault's theory of power and Bourdieu's theory of habitus. The data is analysed thematically using Braun and Clarke's (2006) method.

Findings and Discussion

The key themes emerging from the data are the governance officer role; pleasures and pains; unity versus diversity; in pursuit of accountability; the dual role of the governance officer (policing and nurturing); self-perception and perception of others; complex connections. Surveillance, a network of interactions and power dynamics influence how governance officers ensure accountability and this shapes their identity.

Recommendations

The major recommendations of the study are to review training relating to the governance officer role; to streamline processes in order to efficiently enhance accountability; to develop the role of the governance officer and its positionality within ensuring accountability, by the formation of Communities of Practice in order to enhance their identity and professional standing.

Conclusion

This study has addressed a gap in knowledge by providing an insight into the governance officer's role. This pivotal role is important in ensuring accountability at the local level of the NHS and also in providing high-quality patient treatment and care.

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Abbreviations

AHPs:	Allied Health Professions
AMED:	American and Allied Medicine
BA:	Bachelor of Arts
BMA:	British Medical Association
BNI:	British Nursing Index
BSc:	Bachelor of Science
CASP:	Critical Appraisal Skills Programme
CCGs:	Clinical Commissioning Groups
CD:	Clinical Director
CINAHL:	Cumulative Index of Nursing and Allied Health Literature
CQC:	Care Quality Commission
CV:	Curriculum vitae
DH:	Department of Health
DHEW:	Department of Health, Education and Welfare
DHSC:	Department for Health and Social Welfare
ED:	Emergency Department
EMBASE:	Excerpta Medica database
GCSE:	General Certificate of Secondary Education
GO:	Governance Officer
GP:	General Practitioner
HDAS:	Healthcare Database Advanced Search
HEE:	Health Education England
HMIC:	Health Management Information Consortium
IG:	Information Governance
IGRs:	Integrated Governance Reports
IM&T:	Information Management and Technology
IPA:	Interpretative Phenomenological Analysis
IRAS:	Integrated Research Application Service
LD:	Learning Disability

MBA: Master of Business Administration

MBBS: Bachelor of Medicine

MEDLINE: Medical Literature On-Line

MES: Medical Engagement Scale

MMAT: Mixed Methods Appraisal Tool

MPH: Master of Public Health

NASEM: National Academies of Sciences, Engineering and Medicine

NHS: National Health Service

NHSLA: NHS Litigation Authority

NICE: National Institute for Health and Social Care

NMC: Nursing and Midwifery Council

OP10: Operational Policy 10

PEO: Population-Exposure-Outcome

PhD: Doctor of Philosophy

PRISMA: Preferred Reporting Items for Systematic reviews and Meta-Analysis

PsycInfo: Psychological Information database

PWLDs: People with learning disabilities

QRV: Quality Review Visit

R&D: Research and Development

RCA: Root Cause Analysis

SLA: Service Level Agreement

SUI: Serious Untoward Incident

UK: United Kingdom

UNICEF: United Nations International Emergency Fund

USA: United States of America

ViEWS: Vital Early Warning Signs

VTE: Venous Thromboembolism

Glossary of Terms

Audit convenor – Usually a consultant, responsible for managing and promoting audit activity within the directorate. Works in liaison with the governance officer.

Clinical audit – A quality improvement process to improve patient outcomes. Involves assessing current practice against set standards and generating actions to improve performance, where necessary.

Clinical director – Provides clinical leadership, management and support to the directorate. Has overall accountability and responsibility for governance within the directorate.

Clinical governance officer (Governance officer) – Responsible for ensuring that the governance agenda is followed by providing guidance, coordinating and facilitating its local delivery.

Community of Practice – A group of people who share a common interest in a profession. Sometimes created with the aim of gathering knowledge relating to the field. Could serve as a means of learning.

Consultant – A senior doctor who provides expert clinical advice on a specialised area of medicine. Has responsibility for the care of patients and manages the activities of junior doctors.

DATIX – A patient safety and risk management software system used to manage incidents, risks, claims and complaints.

Directorate – An area within the hospital comprising specialist staff who provide service to patients, e.g., Head and Neck directorate, Obstetrics and Gynaecology directorate.

Directorate manager – A member of staff with responsibility of managing the administrative affairs of a directorate.

Division – A multi-functional area comprising a group of directorates, e.g., Surgical Division, Medical Division.

Duty of Candour – The obligation to be open when Moderate Harm or above has been caused to a patient. The patient or next of kin should be informed, an apology given and an offer of the outcome of investigation should be made.

External visit – A visit made by an external agency, such as CQC, NHS England, Public Health England **–** to assess, inspect and review various aspects of service.

Governance lead – A member of staff responsible for the management of governance issues within a directorate. Main contact for the Governance Department.

HealthAssure – A software system for addresing governance-related activities, such as NICE Guidance Management.

Healthcare governance manager – Leads a team responsible for the implementation of the governance agenda across a Division.

IGR – An integrated governance report comprising a directorate's performance on all governance-related activities.

Incidents – Unexpected occurrences relating to the treatment of patients. These are reported on Datix.

Intranet – The internal website that provides information to staff.

Matron – A senior nurse involved with managing the work of a group of nurses and staff within a directorate. Responsible for ensuring that patients receive high-quality care.

Moderate harm – Where an incident has resulted in a moderate increase in treatment, such as an unplanned return to theatre, an unplanned readmission, a longer episode of care or more time in hospital. Where this has caused significant, but not permanent harm to a patient.

Monitor – An organisation under NHS Improvement, aimed at protecting the interests of NHS patients and improving patient treatment and care.

National audit – Provides an assessment of patient treatment and care on a national scope. Helps to improve performance and ensure uniform patient treatment and care across the UK.

NICE guidance – Guidance recommended by the National Institute for Health and Care Excellence for evidence-based treatment of patients.

Senior managers – Staff occupying executive administrative levels within an NHS Trust, including medical directors.

Shared learning – Sharing knowledge and experience in order to improve patient outcomes.

SUI (Serious Untoward Incident) – An unexpected incident which has consequences that are significant, with a great scope for learning.

SUI action – An action that is generated as a result of a SUI. Should be effective and robust to ensure that the incident does not reoccur.

Table-top meeting – Meeting undertaken following a serious untoward incident (SUI) as part of a root cause analysis. Aimed at investigating the incident and generating actions to prevent a reoccurrence.

To chase – To actively follow-up on previous requests for feedback from the directorates.

Trio – The tripartite within a directorate. Comprises the clinical director, manager and matron.

Trust Board – The apex body in the Trust involved with providing and maintaining the strategy and vision.

Chapter One

Introduction to the Study

1.1 Introduction

The National Health Service (NHS) has always been highly scrutinised and issues of accountability have, for some time, been the basis of discussions. Following a series of recent failings in the provision of care, the NHS was facing its biggest challenge since inception in 1948. In order to prevent the situation from becoming unsustainable, issues had to be addressed differently. This led to the introduction of clinical governance and the accompanying employment of clinical governance officers to ensure accountability at the local level of the NHS.

The aim of this thesis is to explore the perspectives and experiences of governance officers regarding their role in the NHS. The thesis focuses on how governance officers ensure accountability at the local level of an NHS Trust. The original contribution of the study is to fill the gap in the existing pool of knowledge about the experiences of governance officers in an NHS Trust.

This chapter sets the thesis background and it provides the historical context of the study. The chapter also introduces my ontological and epistemological perspectives and it gives some information on my background and how this has influenced the study. In addition, the

chapter discusses the concept of clinical governance and accountability, including the role of the governance officer. It finally presents the structure of the thesis.

1.2. Context to the study

1.2.1 Historical context

The NHS was established after the Second World War in 1948 to improve access to care and treatment for the general public and to provide the United Kingdom (UK) with a 'model' state healthcare system (NHS Act, 1946). The mandate was to provide healthcare services that were comprehensive, free and of high quality to all at the point of need. When the NHS was set up, there were no strategic arrangements for ensuring that high-quality treatment and care should be available to patients (Flynn, 2002). In the first decades, efforts made to improve quality took the form of human resources and infrastructural development – staff, buildings and equipment (Nicholls *et al*, 2000). It was felt that the provision of infrastructure and the skills of the doctors and nurses acquired through training and education, including their 'professional' ethos, would enable quality to be embedded into the care that was provided (Freedman, 2002).

It was only much later that a plethora of strategies began to be put in place to improve the quality of patient treatment and care. These strategies helped to create a new language and conceptual framework

within which the NHS had to operate. In 1983, in a bid to enhance the use and management of manpower and resources, a 'management-focussed' leadership concept was introduced through the Griffiths report (Griffiths, 1983; Watson, 2005). The report highlighted that:

> *A strong general management body is necessary at the centre (and that is almost all that is necessary at the centre for the management of the NHS) to ensure that responsibility is pushed as far down the line as possible, i.e., to the point where action can be taken effectively. At present, devolution of responsibility is far too slow because the necessary direction and dynamic to achieve this is currently lacking* (Griffiths Report, 1983, p. 12).

The growing emphasis on management led to a considerable investment in initiatives that changed clinician-manager relationships within the NHS. Additional accountabilities which involved finance and directorate issues were integrated into the new roles that were created. Specific roles such as medical director, clinical director and head of nursing were introduced (Griffiths, 1983; Rowe and Calnan, 2006). The arrival of business managers or directorate managers in the 1990s challenged the power base of clinicians, as they had to be accountable and report on fiscal issues (Brown *et al*, 1994; Edwards, 2003; Som, 2005). For the purpose of this thesis, clinicians will imply doctors. This is the main frontline staff group that governance officers interact with in a bid to ensure accountability at the local level.

In the past years, public awareness and expectations of care and treatment increased with patient involvement, including the introduction of patient charters (DH, 1991). This created stronger patient rights and

contributed to the calls for enhanced accountability. The charters were said to 'empower' the patients and led to them being treated as 'customers' by the NHS, with entitlements to certain rights and standards of care (DH, 1991; Spurgeon, 1998; Sale, 2005; DHSC, 2021). Moreover, there has been better education and increased awareness and interest in health-related issues (Wright, 2003; McSherry and Pearce, 2007). These moves, together with the streamlining of the complaints process, heightened emphasis on quality and good practice. This placed an obligation on clinicians to be more accountable, not only to patients, but also to the public and relevant external organisations. Where expectations of patients and carers about healthcare were not being met, it led to an increase in the number of complaints and litigations which have increased over the years (Swage, 2004; McSherry and Pearce, 2007; Triggle, 2012; Gottwald and Lansdown, 2014).

In the 1990s, a new strategy was introduced that changed the situation within the NHS (Watson, 2005). This was the internal market or quasi-market where purchasers (buyers of healthcare, i.e., the General Practitioners (GPs) and the providers (sellers of healthcare, i.e., the hospital Trusts) were created. The market allowed commissioners to purchase services from independent sector providers who had to compete for business by offering more efficient service.

In order to achieve high standards, ensure good-quality healthcare and also facilitate and monitor the performance of target-setting, both the

purchasers and providers signed legal contracts known as Service Level Agreements (SLAs). Hospital Trusts were responsible for delivering the levels of care specified within the contracts (DH, 1989). This was accompanied by a focus on cost efficiency and financial management within an internally competitive market. In 1997, the White Paper, *A First-class Service*, was introduced to set clear standards, to deliver high-quality healthcare and monitor progress. Another White Paper, *the New NHS: Modern, Dependable* was published two years later. This paper made it statutory to report on quality issues (DH, 1997; DH, 1998) – it heralded the beginning of clinical governance.

The general drivers for change in the NHS include the population profile, technology and innovation, patient expectation and political factors, such as policy directives (HEE, 2017). However, the concern for clinical governance also arose because the NHS had been struggling to provide a uniform quality of healthcare. Widespread variations in clinical practice occurred amidst allegations of deficiencies of care and serious neglect of patients (Halligan and Donaldson, 2001; Zahir, 2001; Lugon, 2006). Clinical failures made headline scandals and resulted in public trust levels falling and a number of inquiries being set up: Bristol Inquiry; Death by Indifference; the Mid-Staffordshire Inquiry (Kennedy, 2001; Walshe and Higgins, 2002; Mencap, 2007; Francis, 2013).

With the introduction of clinical governance also came new types of relationships between doctors, patients, the public and the NHS. Clinical

governance challenged the authority of clinicians, who now had to account for the care that is provided to patients.

1.2.2 Clinical failings in patient care

A number of high-profile clinical failings were reported in some Trusts across the UK (Gottwald and Lansdown, 2014). More recently, there have been reports of unnecessary operations on patients and also the mistreatment of maternity cases in Shrewsbury and Telford Hospital Trust (DHSC, 2020a; DHSC, 2020b).

It is interesting to note that the majority of these incidents were first highlighted by patients' families and had been missed by regulatory bodies, such as the Care Quality Commission (CQC). The failings led to inquiries and the subsequent release of reports which recommended radical changes. Recommendations included the setting of standards by the National Institute for Health and Care Excellence (NICE). Other recommendations were enhanced training, continuous professional development, appraisals and revalidation for clinicians. Some of the reports include:

(2001) *Learning from Bristol:*
This report, written by Professor Ian Kennedy (2001), revealed significant clinical and organisational failings among babies that received complex cardiac surgery. The incidents occurred at the Bristol Royal Infirmary between 1984 and 1995. The report concluded that about 30 more deaths

had been recorded from paediatric surgeries than were expected. An anaesthetist exposed this high mortality rate which led to a public inquiry. A total of 198 recommendations regarding service organisation, leadership, safety, professional competence, public involvement and the care of children were put in place (Kennedy, 2001).

(2007*) Death by Indifference Report:*

This report was commissioned and written by Mencap, a leading charity organisation working with people with learning disabilities (PWLDs). The report highlighted the neglect and poor access to healthcare that led to the premature deaths of the PWLDs. Institutional discrimination within the NHS against people with learning disabilities was identified, as no actions had been taken following earlier reports. The need to understand and ensure that people with a learning disability are treated decently and equally was emphasised (Mencap, 2007).

The recommendations were that a confidential inquiry should be conducted for all premature deaths of people living with a learning disability and for the complaints system to be reviewed. Other recommendations were mandatory training for all clinicians looking after PWLDs, the availability of a disability liaison office, provision of documentation to readily identify PWLDs and for family and carers to be involved in the care of PWLDs.

(2013) *Mid-Staffordshire Inquiry:*

Sir Robert Francis' report (Francis, 2013) revealed substandard care and treatment in the mid-Staffordshire NHS Foundation Trust between 2005 and 2009. The report concluded that many of the failures were caused by focussing on achieving targets and cutting expenditure. The Trust concentrated on ensuring that it was financially well-positioned, to the detriment of patient safety and quality of care. Furthermore, the organisational culture and management of the Trust had resulted in failures of care that went unnoticed even by a number of external supervisory bodies. These bodies included the CQC, Monitor and the Health and Safety Executive.

Within the mid-Staffordshire Foundation NHS Trust, there were cases of serious neglect of patients leading to poor patient care, immense suffering and high mortality rates. The findings of the inquiry showed that there were negative cultures which had led to professional disengagement and poor governance. The Francis Inquiry concluded that many of the failings were as a result of the tension between financial constraints and the delivery of quality care to patients which resulted in systematic and prolonged failures of care (Francis, 2013).

A total of 290 recommendations were generated which related mainly to culture change. The changes had widespread implications on the current operations of governance in the UK. For instance, the complaints system was strengthened and there were new standards for non-compliance

(including a requirement that staff should be encouraged to report non-compliance). In addition, a statutory Duty of Candour was imposed and shared learning was encouraged across the NHS.

(2015) *Morecambe Bay Investigation:*

Following concerns by relatives over the occurrence of serious incidents in the maternity services of the University Hospitals of Morecambe Bay NHS Foundation Trust, an investigation was set up. The investigation revealed failures in the delivery, management and outcomes of clinical care in the maternity unit between 2004 and 2013. This led to avoidable maternal and infant deaths. The failures extended to the agencies that were responsible for monitoring and regulating the Trust. Specifically, clinical competence within the Trust was sub-standard, work relations were poor and response to incidents was deficient.

The recommendations that were generated have influenced contemporary governance. They brought about enhanced risk management, robust audit activity, strengthened complaints processes and raised awareness on incident-reporting and mortality. There were recommendations for the Clinical Commissioning Groups (CCGs), CQC and Monitor. These recommendations were put in place to ensure that risks are reduced across the country and that the quality of care provided to patients is improved upon (Kirkup, 2015). Table 1 is my modification

of a table by Walshe and Higgins (2002) showing a selection of inquiries that were set up following clinical failings between 2000 and 2018.

Table 1: Selection of major NHS inquiries - 2000 to 2018 (modified from Walshe and Higgins, 2002)

Date	Issues	Inquiry details	Patient category involved	Recommendations
2000	Serious failings in clinical practice and managerial arrangements for the removal, retention and disposal of human tissue and organs from children after death at the Royal Liverpool Children's Hospital (Alder Hey).	Independent confidential inquiry set up under Section 2 of NHS Act 1977. Conducted via closed hearings. Had 6 weeks of hearings, with 120 witnesses, scrutinised 50,000 pages of documents. Inquiry took 14 months.	Children	Approximately, 67 recommendations covering changes to NHS/university structures, coroners' role and function, consent arrangements, and wider systems for dealing with the bereaved.
2000	Serious failures in the clinical practice of Rodney Ledward at the South Kent Hospitals NHS Trust between 1990 and 1996 were documented and confirmed.	Independent confidential inquiry commissioned by the Secretary of State. Hearings conducted in confidence with no powers to summon witnesses or evidence. Heard from over 160 patients and many other witnesses. Inquiry took 14 months.	Mental Health	Made 103 recommendations for changes to quality systems in the NHS and private sector.

Date	Issues	Inquiry details	Patient category involved	Recommendations
2001	High mortality rate in paediatric surgery at the Bristol Royal Infirmary for children receiving complex cardiac surgical services between 1984 and 1995. Serious clinical and organisational failings. There were more than 30–35 avoidable deaths.	Public inquiry set up under Section 84 of NHS Act 1977 chaired by Professor Ian Kennedy. Conducted in public with powers to summon witnesses. Had 96 days of hearings, with 577 witnesses examined 900,000 pages of documents including 1,800 patients' medical records. Inquiry took 2 years 9 months.	Children	Made 198 recommendations regarding service organisation, leadership, safety, professional competence, public involvement, and the care of children.
2001	The conduct of Dr Harold Shipman, a general practitioner in Hyde, Greater Manchester, who was convicted in January 2000 of murdering 15 patients. He was reported to have killed a total of 215 patients between 1974 and 1998.	Public inquiry set up under Section 1 of Tribunals of Evidence (Inquiries) Act 1921 chaired by Dame Janet Smith. Conducted in public with powers to summon witnesses. Inquiry started in February 2001.	Adults	Recommendations included the review of death investigation and certification processes; a review of systems to monitor GPs, including revalidation and the inspection of GPs' controlled drugs register.

Date	Issues	Inquiry details	Patient category involved	Recommendations
2003	The scandal of substandard treatment and care in the mid-Staffordshire NHS Foundation Trust.	Sir Robert Francis' report into the inquiry reported failures of care, negative cultures, professional disengagement and poor governance. Target-setting and cost-cutting reportedly brought about poor patient care and high mortality rates. Understaffing led to patients enduring unnecessary suffering and being routinely neglected as financial considerations overrode clinical concerns.	Adults	Made 290 recommendations which included always placing the patient as a priority, reference to NHS Constitution, enhanced incident-reporting and shared learning, professional body involvement, extra powers for health regulators, organisations to be honest, open and truthful and to apply the Duty of Candour where death or serious harm has been caused.
2004	Inquiry into hyponatraemia-related deaths of five paediatric inpatients.	A report, *Hyponatraemia-related deaths,* was released in 2018.	Children	Weakness in safety with the systems and individual and corporate underdevelopment. The recommendations included a statutory Duty of Candour to be enacted in Northern Ireland.

Date	Issues	Inquiry details	Patient category involved	Recommendations
2007	Avoidable deaths of people with learning disabilities due to inadequate treatment and care.	A report, *Death by Indifference*, highlighted people with learning disabilities died unnecessarily while under the care of the NHS. A 3-year inquiry revealed that 37% of deaths were preventable.	People living with learning disabilities	Recommendations included mandatory training for health practitioners treating people with learning disabilities, data for identification of people with learning disability to be readily available, family and carers to be involved in their care and regular annual checkups.
2013	Morecambe investigation into maternal and neonatal deaths.	Report highlighted political issues, staff incompetence, poor working relations, inability to investigate adequately and learn lessons, and lack of openness.	Mothers and babies	Recommendations included offer of apology to patients and relatives; review of competency, skills, knowledge; provision of training, promotion of multidisciplinary working and an effective recruitment and retention strategy.
2018	Approximately, 456 patients died unnecessarily from the misadministration of opiates at Gosport War Memorial Hospital.	Morphine and other pain-relieving drugs were prescribed to elderly patients unnecessarily. Issues included staff incompetence, inadequate technologies and staff training.	Adults	Recommendations included investigations into individual deaths, study of shift patterns and improvement in hospital practices.

Although the above reports may seem relatively few in the context of the wider positive impact of the NHS, it was evident that the monitoring systems and the mechanisms that were in place were failing. A more formalised clinical governance framework would aim to address the above issues. This would ensure that directorates are accountable for providing good-quality service and treatment to patients. It would also broaden the focus from management and financial issues to clinical quality (Shapiro, 1998; DHSC, 2010; Francis, 2013).

There have also been an increase in demand for NHS services and a rise in public expectations of the NHS, as evidenced by the number of complaints. In 2019, monthly outpatient attendances for the UK were 1.5 –1.6 million with 700,000 elective admissions and 500,000 non-elective admissions (House of Commons Library, 2019). In 2019/20, the total number of new complaints was 113,241. In 2018/19 and 2017/18 respectively, the total number of new complaints was 116,247 and 113, 989 (Digital NHS, 2020). If the quality of healthcare was to improve, there had to be enhanced accountability within the NHS.

1.2.3 Challenges facing the NHS

The NHS is a highly scrutinised and often criticised entity in media and political circles. Some of the issues facing the organisation arise from domestic and global economic problems. This economic climate has affected many services, including the NHS which has, for some time, been

operating under huge pressure (Dubnick and Frederickson, 2014; Gibbons, 2016; The King's Fund, 2017). Patient safety could also be compromised, because of lack of funding and inefficient systems (Vincent *et al*, 2013; NASEM, 2016).

The NHS is one of the largest institutions of public expenditure in the UK. There are, therefore, increasing pressures for more attention to accountability (Donaldson, 2001; Merali, 2009). The organisation is operating under financial and clinical pressures in an austere economic climate. This study began before the COVID-19 pandemic. The pandemic has exacerbated these pressures and also highlighted the impact of years of austerity measures on the NHS.

Apart from the rising costs of services, there is an increased demand from an ageing population with increasing complex morbidities, i.e., cancers, heart attacks, strokes, etc. (BMA, 2014; Gibbons, 2016; The King's Fund, 2017). Diseases arising from lifestyle factors, such as excessive alcohol intake, smoking, obesity and lack of exercise have also placed a strain on services (Garelick and Fagin, 2005; DHSC, 2010). The inequalities and variations in standard of care and practice in the NHS and the headline scandals in some Trusts have also led to questions about accountability (Kennedy, 2001; Francis, 2013). As a result, the public culture regarding the NHS is no longer based on ideas of 'trust', but on ideas of 'accountability' (Mechanic, 2004 in Rowe and Calnan, 2006).

A Five-year Forward View was put in place in 2014 and it proposed savings to allow the NHS to withstand financial pressures arising from the increasing patient demand and funding constraints (House of Commons, 2017). As a result, since 2017/18, growth in NHS expenditure has slowed down considerably and the annual increase in budget spending has been cut down to 0.7%. The shortfall in funding, currently 0.1% a year, has caused targets to be put in place to accrue savings of £30 billion by 2020/21 (The King's Fund, 2017). This was expected to be achieved by reducing waste and improving efficiency.

In the 2020/21 financial year, the Department of Health planned spending was £212.1 billion for the population of England. In 2019/20, it was £150.4 billion. A good proportion of this increase was due to additional funding in response to the COVID-19 pandemic. Strain and tension are being felt in all areas of healthcare and it is imperative that radical changes are put in place in order to improve accountability and enhance patient safety. Savings need to be made in order to target specific areas where the money is required the most.

The economic environment has negatively affected healthcare delivery in general practices, mental health and community services. Where there are constraints between health and social care funding, older people are kept in hospital due to inadequate community and social support. The delays in discharges then lead to losses in bed days. The situation also increases patient mortality, length of hospital stays and it impacts

negatively on patient satisfaction (The Kings Fund, 2017). In 2018, emergency admissions into hospitals rose by 6.7% and the number of attendances to emergency departments rose by 0.6%. In the same year, figures from the emergency and cancer departments showed that standard waiting times have increased and targets are not being met. The NHS target for people waiting for four hours is 95%. The two-week wait targets for cancer patients for a GP referral to a consultant and 62 day waits from consultant to first treatment are 93% and 85% respectively. The percentage of people spending more than four hours in all emergency departments in England was 12.0% (88% seen under four hours) in 2018/19, while the target for cancer patients to be treated within two months of GP referrals has not been met since 2013 (House of Commons Library, 2019), illustrated in Tables 2 and 3.

Table 2: Emergency attendances and waiting times
(Adapted from House of Commons Library, 2019)

	Total Emergency Attendances (per day)	**Percentage waiting over 4 hours in ED**	**Total Emergency Admissions** (per day)	**Number waiting 4 hours for Emergency Admissions**
2013/14	59,668	4.3%	14,446	168,181
2017/18	65,288	11.3%	16,484	618,130
2018/19	67,991	12.0%	17,449	628,816

Table 3: Cancer waiting times

	Urgent GP referral for consultant appointment (per day)	**More than 2 months for first treatment after urgent GP referral** (per day)
2013/14	3,000+	300+
2017/18	5,000+	400
2018/19	6,000+	400+

The waits have increased greatly during the COVID-19 pandemic. This reflects the wider pressures on the health system. These waits create tension, poorer patient outcomes and complaints. They have been brought about mainly by lack of access to GP appointments, lack of out-of-hour care, delayed discharges, poor strategic decisions and budget cuts (The Kings Fund, 2017).

1.2.4 Ensuring accountability

Accountability has been described as 'the process of being called to account to some authority for one's actions' (Mulgan, 2000). The papers, *High Quality Care for All, A First-Class Service* and *Equity and Excellence* clearly highlight the importance of enhancing accountability in the NHS and also its intentions of placing quality at the top of the agenda (DH, 1998; DH, 2008b and DHSC, 2010). The White Paper, *The New NHS: Modern, Dependable,* (DH, 1997) made accountability a statutory duty.

Providing accounts for the actions for which they are held responsible seems to have provided good dividends, as reports of high levels of

patient satisfaction, improving outcomes and overall efficiency have been made (DH, 2017a). Enhanced accountability can potentially improve communication with patients, improve performance and cut down the numbers of incidents and complaints.

The implementation of a new service model rolled out as part of the NHS Long Term Plan (DH, 2017b) aimed to enhance patient care. It involves the integration of primary, specialist, mental, health and social care. The model also maximises the use of technology and it empowers patients to manage their own health. Arms-length regulation will cease and improvements will be supported from within. There will be appropriate governance models and strong governance and accountability mechanisms at board and local level in order to maximise value from the integrated system.

The chains of accountability are imperative for maximising returns on investment of taxpayers' funds. Within the NHS, accountability can be classified into three main levels (Maybin *et al,* 2011):

1. Strategic level (accountability to NHS England)
2. Local level (accountability at directorate level to committees within the Trust)
3. Organisational level (accountability to patients, community, external organisations, such as CQC).

1.2.5 Clinical governance

Clinical governance has been of increasing importance as a quality improvement vehicle in the NHS. It is aimed at providing high-quality care that is safe, patient-centred and continuously improving (Ritchie, 2002; Wright and Hill, 2003; Swage, 2004; McSherry and Pearce, 2007; Gottwald and Lansdown, 2014). A common definition of clinical governance is:

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

It has also been described as comprising steps and procedures which would ensure that patients receive the highest quality care (Commission for Health Improvement, 2002).

1.2.5.1 History of clinical governance

Some form of clinical governance can be traced to Hippocrates as far back as 400BC. Good-quality healthcare and accountability is highlighted in the Hippocratic Oath. Although it has been modified over time, the ethical issues highlighted in the oath are relevant expectations of medical practitioners today. The oath emphasises the importance of respect, beneficence and non-maleficence, eschewing corruption and maintaining confidentiality (Edelstein, 1996). Although some will argue about the relevance of the Hippocratic Oath in the contemporary 21st century NHS, it lays down some of the expected practice in the medical profession.

In the 1850s, Florence Nightingale wrote about the level of care that was being provided to wounded soldiers in Crimea. She highlighted some ways of improving the substandard care. She wanted the professionalisation of nurses, and with that came standards (Goldie, 1987). Professionalisation was then so successful that doctors and nurses came to be treated as all powerful. As discussed below, between 1948 and now, a plethora of quality assurance tools have, therefore, been introduced to enhance the level of patient care (Sale, 2000; Swage, 2004; McSherry and Pearce, 2007).

Since the inception of the NHS, there have been multiple radical changes. Medical audit, an early form of quality improvement, was developed by the Department of Health. It involved systematically evaluating the quality of patient care that was provided against set standards. The term 'medical' was later changed to 'clinical' to encompass all clinicians and it remains one of the cornerstones of clinical governance. There is now more emphasis on clinicians to engage in audit and to be more accountable in order to ensure high standards of patient care and safety (Spark and Rowe, 2004; Swage, 2004; NICE, 2006).

The initiative for clinical governance originated from ideas of corporate governance and the directing and controlling of operations of companies. In 1992, the Cadbury Committee put forward the Cadbury Code which highlighted the principles of Good Corporate Governance. Its salient recommendations were that boards of directors should ensure firm

control on operations in order to protect the interest of the stakeholders. In addition, the boards of directors were to produce annual reports for the shareholders highlighting the current position of the organisation (McSherry and Pearce, 2007). Strategic goals were set with policies and guidelines to steer direction, ensure accountability and define the culture of the organisation. The Cadbury Code ensured that performance is monitored in a transparent manner and appropriate actions are taken to ensure that the expected outcomes are met (Storey, 2011).

The principles of corporate governance were incorporated into the NHS in 1994, with a view to harnessing some of its benefits (McSherry and Pearce, 2007). The benefits included improved channels of communication, protection of employee and public interest and good returns on investment. The publication, *Corporate Governance in the NHS; Code of Conduct and Code of Accountability* (DH, 1994), required NHS Trust boards to ensure accountability, probity and openness – mainly in relation to finance and operations of healthcare. The clinical aspects of healthcare were addressed under another strand of governance called clinical governance.

Clinical governance began to be seen as a systematic model of quality improvement and an important tool that the government could use to realise the governance agenda in healthcare (Gottwald and Lansdown, 2014). Its origin can be traced to the White Paper, *The new NHS: Modern, Dependable* (DH, 1997). This paper re-established the NHS as an

organisation where all patients should receive unconditional high-quality care. This would be based upon best practice and collaborative working partnerships. Furthermore, the paper emphasised a positive culture where quality was at the heart of everything, in order to enhance public confidence (DH, 1997).

The paper, *A First-class service: Quality in the new NHS,* provided detailed information on measures required to develop clinical governance. It highlighted that clinical governance was aimed at improving upon the quality of health, enhancing service accessibility and ensuring consistency in healthcare provision. The paper also recommended removing the divisions between parts of the health and social care system (DH, 1998). It is worth noting that some other aspects of what was being required in clinical governance were in place before the White Papers, e.g., medical audit and risk management (Spark and Rowe, 2004).

Table 4 shows White Papers that have focussed on quality enhancement in the NHS (DH, 1944; DH, 1997; DH, 1998; DH, 2008b; DHSC, 2010).

Table 4: Major NHS White Papers

Year	White Paper
1944	A National Health Service
1997	The New NHS: Modern Dependable
1997	Designed to Care
1999	A First-Class Service: Quality in the New NHS
2008	High Quality Care for All
2010	Equity and Excellence: Liberating the NHS

1.2.5.2 Clinical governance and accountability

Today, accountability is seen as a major cornerstone of clinical governance in the NHS (Dewar, 2000; Donaldson, 2001; Peak *et al*, 2005; Maybin *et al*, 2011). In the paper, *A First-Class Service: Quality in the New NHS* (1998), Trusts were tasked with establishing clear lines of accountability and also reporting on the quality of treatment and care. Individuals were responsible for improving quality, and frameworks, processes, structures and systems were established in order to ensure accountability. The lines of accountability and the mechanisms that are in place enable the measurement of performance for monthly reporting and addressing of concerns to the Trust Board. Although individuals are

accountable for local performance, the Board of directors would ultimately be accountable for the quality of care that is provided.

Clinical governance was to be the bridge linking the relevant staff groups together as they aimed to deliver high standards of patient care. It changed the culture and the nature of relationships between the clinicians, patients and managers. Essentially, clinical governance links the senior NHS managers, responsible for translating management initiatives into governance strategies via guidelines and policies with the clinicians. Clinicians use their expertise, professional knowledge and skills to care for and treat patients, thereby providing high-quality standards of care. Trusts are mandated to ensure that there are appropriate structures which provide assurance that responsibilities for ensuring high-quality treatment and care are in place (DH, 1998; DH, 2008b).

Governance structures provide effective means of implementing policies and guidelines. They support the clinicians by helping them to meet the governance agenda and to be accountable for their duties and responsibilities. In order to manage the system, there was a requirement for administrators who will do the 'administrative work'. Clinical governance officers are employed to address the governance agenda. The terminology given to this staff group varies from Trust to Trust. Similar functions are carried out by governance officers, governance facilitators, quality assurance officers, quality improvement officers, compliance officers, etc. The absence of a consistent title and job specification across

the NHS reflects the lack of coordination which also allows different Trusts across the country to have different accountability outcomes. Notwithstanding this, the aim of the 'Governance Department' is to ensure the provision of good-quality service and treatment to patients. In this thesis, I will refer to the Governance Department and governance officers as generic concepts.

1.2.5.3 The role of governance officers in ensuring accountability

Given their central role in administering clinical governance, governance officers are seen to play a part in building a reputation of excellence and improving the culture of compassion, safety and high quality. This involves harnessing and efficiently channelling all resources and bringing liabilities, such as claims and litigations, to the barest minimum.

Governance officers have the primary responsibility of providing support and assurance to directorates in order to ensure good governance. Their responsibilities cover areas such as Clinical Audit, Incident and Risk Management, Claims and Complaints Management. They support directorates in providing safe and effective patient care, while ensuring accountability. In other words, they are the operational 'custodians' of clinical governance. In theory, they are united by the main objective of continuously improving upon the quality of service provided by the organisation and also of safeguarding high standards of care. In this way, governance officers are positioned to act as change agents and not

merely as administrators. They support clinicians with the implementation of strategies and policies set by senior managers, and they also provide assurance to the managers that the governance agenda is being followed within the directorates.

Governance officers work closely with the directorate management team. Their role is to ensure good governance according to laid-down procedures. Although governance officers are graded in the middle of the pay structure, the two groups that they find themselves between, are significantly powerful staff who are at the top of their careers. The senior managers are responsible for translating management initiatives into governance strategies via guidelines and policies. These managers are entrusted with the responsibility of ensuring that clinicians are compliant to policies and procedures, both individually and corporately, and that they provide high-quality standards of care.

1.3 Perspectives underpinning the study

1.3.1 My background

My own background is of interest here. I was born and brought up in Nigeria. I studied Microbiology for my first degree at the Ahmadu Bello University, Zaria, Nigeria in 1983. Looking back, my interest in research began in my final year as an undergraduate microbiology student. I was employed as a microbiologist in a food company, Flour Mills of Nig. Plc., Lagos. Prior to joining the NHS in 2008, I worked in diverse areas as: a

secondary school supply teacher, a healthcare assistant, a support worker and an administrative clerk. The experiences gained from the various jobs have enhanced my skillset and have, in one way or the other, played a strong part in influencing my educational background and my career path.

I was employed in the NHS as a clinical audit facilitator. I now work as a clinical governance officer. In 2014, the Governance Department was restructured and specialist roles (audit facilitators, Datix managers, claims coordinators, etc.) were converted to generalist roles. This staff group became known as clinical governance officers.

I was encouraged to undertake a doctorate course by one of the senior lecturers while I was doing an MPH course. My choice of a research study has been out of personal interest. My study has been guided by my current job and it lies within my scope of knowledge. Undertaking the PhD course is the fulfilment of a lifelong ambition.

Having trained first as a microbiologist, I was originally interested in the positivist approach. Microbiology involves measuring, counting and observing microorganisms under a variety of conditions as well as, studying laws and theories, testing hypotheses and setting controls. Every task is objective – structured and factual. Unsurprisingly, my first research project was quantitative and I leaned towards positivism. I later undertook a part-time Master's course in Business Administration (MBA)

which exposed me to qualitative techniques. This was a new approach to reasoning for me.

In 2005, I travelled to the United Kingdom for a Master's degree in Public Health (MPH). The course further increased my awareness of the social sciences and qualitative paradigms. I now appreciate qualitative techniques as being valuable in the generation of knowledge. I acknowledge that people view the world in different ways (May, 2005). My ontological assumptions are that there are multiple perceptions and there are different ways of seeing and constructing reality, which form a body of knowledge. There are no absolute truths and the responses provided by the participants should not be deemed as right or wrong. Instead, it is important to see how different people see the world.

1.3.2 Philosophical perspectives

All research is based on certain ontological and epistemological approaches. Ontology and epistemology refer to how knowledge assists in making sense of reality and also the nature of interactions involved. Making these assumptions explicit sets the expectations of the research and provides an enhanced understanding. How ontology and epistemology form the bedrocks of the study and the underpinning points upon which the general methodology, the approach to the literature, research design and specific methods, are discussed in Chapter 3 – the Methodology Chapter.

My research study has a social constructivist perspective.

> *Social constructivists believe that individuals seek understanding of the world in which they live and work. Individuals develop subjective meanings of their experiences – meanings directed towards certain objects or things. These meanings are varied and multiple, leading the researcher to look for the complexity of views rather than narrowing meanings into a few categories or ideas. The goal of the research is to rely as much as possible on the participants' view of the situation being studied* (Creswell, 2013, pp.24-25).

My epistemological perspective is that knowledge can be obtained through the interactive process that exists between the participants and the researcher. The presence of the researcher immediately alters that which is being studied and the outcome of a research study. The researcher is the pivoting force, influencing the research study - from planning, through data collection, analysis and interpretation. In carrying out this research study, I assume that the perceptions of people and a description of their lived experiences and feelings, expressed through their voices are important as a source of knowledge. To gain such knowledge, there should be a close relationship between the participants and myself.

1.3.3 Interpretivism

From an array of paradigms, I find myself positioned within interpretivism. Interpretivism is based on the interactions and perceptions of individuals from which they create their social world. Phenomenological approaches have been widely used for several decades in health research. Phenomenological researchers have explored

the organisation of health provision, specific institutions and the experience of different groups, including clinicians, trainees, patients, etc. What links this approach over these different areas is the way that phenomenology encourages the researcher to unravel the lived experiences of those involved. In each case, the literature is huge but less developed in terms of administration.

My research study is aimed at providing a rich, in-depth understanding of the role of governance officers based on their perceptions. It acknowledges the depth of the human mind and the participants' abilities to unfold their experiences. The qualitative method of data collection is most suitable for this study. It is apt for anti-positivist assumptions. Knowledge is subjective and the world is understood through the perceptions of others. Qualitative research methods are techniques that explore the meaning that individuals or groups ascribe to their experiences and how they make sense of the social world. Data collected is in the form of descriptive formats which are interpreted using methods such as thematic analysis (Miles *et al*, 2014; Silverman, 2016; Pope and Mays, 2020).

Qualitative data is collected in natural settings. Morse and Field (2013) explain that qualitative studies 'provide a window into the world of others, providing an emphatic meaning of their world.' As they focus on naturally-occurring events, they provide a picture of what the real-life situation is like (Pope and Mays, 2020). The researcher uses this interpretative,

naturalistic approach and makes sense of the phenomena based on the meanings that are provided.

1.4 Structure of the thesis

The thesis comprises seven chapters:

Chapter 1, this introductory chapter, has introduced the study by providing its background and justification. The chapter gives a historical context to the study and it discusses the challenges facing the NHS. It sets out the philosophical and theoretical underpinning of the study. Accountability, clinical governance and the role of the governance officer are discussed.

Chapter 2, the literature review chapter, discusses the literature review process. It explains the search strategy, findings of the review and how they influenced the development of the research aim and research questions. The chapter provides the contextual and theoretical context for the study by exploring literature relating to accountability and also reviewing relevant theories.

Chapter 3 describes the methodology of the research study, i.e., the research process and the research design, including data collection methods. The chapter also discusses the method for data analysis, its strength and limitations. In addition, the chapter presents the ethical considerations of the research study.

Chapters 4 and 5 present the findings of the individual interviews and the focus group, respectively.

Chapter 6, the discussion chapter, explores the perceptions of the governance officers using role theory as the main lens for explaining the data. Foucault's theory of power and Bourdieu's theory of habitus are also used as underpinning theories to explain the data.

The conclusion chapter, Chapter 7, collates the findings of the research and provides key findings of the study. It reflects upon the approaches that have been taken. The chapter also provides the recommendations and highlights the strengths and weaknesses of the research.

1.5 Summary of the chapter

This introductory chapter has provided an insight into the thesis. It has presented the context for the research study. It has also introduced the two relevant terms, accountability and clinical governance. The chapter has discussed the role of the governance officer, as they ensure accountability at the local level of the NHS. It discussed the philosophical underpinnings of the study. It has also provided some information on my position within the study and my background. The next chapter will review the literature that is available on the role of governance officers in ensuring accountability at the local level of an NHS Trust.

Chapter Two

Literature Review

2.1 Introduction

The first chapter introduced the research study by providing its background and justification. This second chapter reviews and evaluates the overall literature. In addition, it validates the research questions and it provides a benchmark against which to compare outcomes of the study (Cooper, 1998; Parahoo, 2014; Polit and Beck, 2018).

This chapter is presented in two parts. Part One discusses the literature search process and it also critiques the selected literature. Part Two provides a review of concepts and theories that are related to the research study. Concepts such as accountability and governance are discussed. The theories that are discussed include role theory (Merton, 1968; Biddle, 2013), Michel Foucault's theory of power (Foucault, 1977; Gordon, 1980; Dreyfus and Rabinow, 1982) and Pierre Bourdieu's theory of habitus (Bourdieu and Passerson, 1977; Bourdieu, 1993; Grenfell, 2014; Costa and Murphy, 2015). Role theory has been chosen as the main theoretical framework that will answer the research questions appropriately. Concepts of role theory such as consensus and conformity, role expectations, role ambiguity, role overload and role conflict are also discussed. The chapter concludes with the development of the research aim, research questions and a justification for the study.

PART ONE

2.2 Review of available literature

2.2.1 Introduction

Types of literature reviews include integrative reviews, meta-analyses, narrative reviews, qualitative and systematic reviews. For this study, an integrative review was undertaken (Cooper, 1998; Whittemore and Knafl, 2005; Torraco, 2016). The initial literature search entailed carrying out a scoping exercise on Google and Google Scholar. This was done in order to have a preliminary idea of the articles that were available. There were many articles on clinical governance and its importance in the drive for quality improvement. However, the majority of the information on clinical governance officers were limited to job advertisements for governance officers in the NHS. It became obvious that there was scanty literature on the role of governance officers and that an integrative literature review would be the best option.

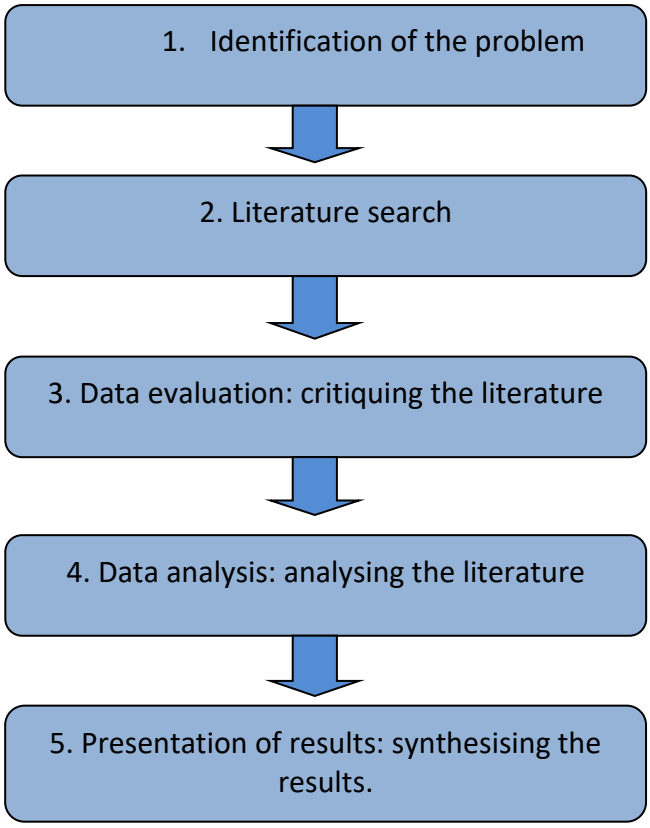
The integrative approach is ideal for addressing new and emerging topics (Cooper, 1998; Whittemore and Knafl, 2005; Torraco, 2016). It would, therefore, provide a comprehensive understanding of the emerging subject area of the role of governance officers. The reason for using the integrative approach for this study was to review the literature, critique and also synthesise the available information on the role of governance officers working in an NHS Trust (Torraco, 2016). The integrative approach was originally developed for systematic reviews by Cooper

(1998) and it was modified by Whittemore and Knafl (2005) in order to align with more diverse methods (Figure 1). Systematic reviews only include quantitative studies and due to the nature of this research study, it is likely to involve little or no quantitative literature. This approach was chosen over the systematic review method, as it allows for a broader range of methodologies (Whittemore and Knafl, 2005).

The strength of the integrative review lies in its rigorous methodology and its ability to summarise and synthesise a wide range of research studies, i.e., both qualitative and quantitative (Toronto and Remington, 2020). The newly-generated framework can be applied to policy, practice and theory development (Whittemore and Knafl, 2005). Other uses of integrative reviews are conceptualising findings in terms of a Community of Practice and identifying future research.

A limitation of integrative literature reviews is that the convergence of the diverse methodologies could complicate issues leading to bias, inaccuracies and a lack of rigour (Whittemore and Knafl, 2005). Synthesising different types of literature sources can be challenging. Rigour can be enhanced by using a framework such as illustrated in Figure 1 (Toronto and Remington, 2020).

Figure 1: Whittemore and Knafl 5-stage theoretical framework for research synthesis



The literature review process followed the above framework as below.

2.2.2 Identification of the problem

A major global health concern has always been how to improve the quality of patient care. Investigations following the highly-reported incidents of unsafe and poor care (discussed in Chapter 1) called for increased accountability. This was not only to ensure good-quality treatment and care, but also to enhance patient safety. Clinical governance has been highlighted in a number of White Papers, (DH, 1998; DH, 2008b and

DHSC, 2010) as a way of ensuring the provision of good-quality patient care. These papers clearly highlight the importance of enhancing accountability within the NHS.

2.2.3 Literature search

An advanced online search was conducted on Open Athens, an information technology service, which provides access to the Healthcare Database Advanced Search (HDAS). The electronic databases that were searched include the American and Allied Medicine (AMED), the British Nursing Index (BNI), Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medical Literature On-line (MEDLINE), Excerpta Medica database (EMBASE); Health Management Information Consortium (HMIC) and PsycInfo (produced by the American Psychological Association). The aim of this search was to retrieve as many appropriate articles as possible from the available literature (Cooper, 1998; Parahoo, 2014; Coughlan and Cronin, 2017). The search focussed on articles relating to governance officers in the NHS.

The specific purpose of this research study is:

To explore the perspectives and experiences of governance officers regarding their role and how they ensure accountability at a local level within the NHS.

The sampling frame for the search was all relevant published literature that focussed on the role of governance officers and how they ensure accountability within the NHS.

The variables that were identified include:

- The role of the governance officer
- The experiences of the governance officer
- How governance officers ensure accountability at the local level of the NHS.

To extract relevant information during the review of the literature, a search question was developed using the PEO (Population-Exposure-Outcome) model (Law *et al*, 1996). This is one of many tools available for developing search questions during a research process. The PEO model was chosen because it is most suitable for use with qualitative studies such as this. It is further illustrated in Table 5.

Table 5: PEO model for literature search

Population	Governance officers working in an NHS Trust
Exposure	Ensuring accountability
Outcome	Governance officers' perception of their roles and experiences

The search question that was formulated using the PEO model was:

What are the roles and lived experiences of governance officers as they ensure accountability at the local level of an NHS Trust?

This search question further informed the keywords that were used:

Governance officer; experiences; accountability; NHS

The search was limited to governance officers because the focus of the study was on governance officers and how they ensure accountability at

the local level. Adding other groups to the search would deviate from answering the search question and this could impact on the trustworthiness of the study.

Using the PEO model, synonyms of the search terms were identified (Table 6). These synonyms were used to broaden the scope of articles that could be retrieved from the databases, so that as many relevant articles as possible could be reviewed.

Table 6: Synonyms using PEO format

Population	Exposure	Outcomes	NOT
Clinical governance office*	Governance	Accountab*	Board*
Governance officer*	Compliance	Responsib*	Trust Board*
Governance facilitator*	Standards	Answerab*	Corporate governance
Compliance officer*	Quality		Financial accountability
Quality assurance officer*	Noncompliance		Information governance
Quality improvement officer*	Quality and safety		Research governance
Quality and safety facilitator*	Policy compliance		
Quality and safety officer*	Quality assurance		
Risk management officer*	Quality improvement		
Quality improvement facilitator*	Risk management		
Risk management facilitator*			
NHS			
National Health Service			
British Health Service			
Health service*			
Healthcare			
Healthcare setting*			
Healthcare system*			

2.2.3.1 Search strategy

It is important that a well-defined search strategy is in place to clarify the search process, reduce bias, maintain rigour and ensure that an accurate result is obtained (Cooper, 1998; Whittemore and Knafl, 2005). Therefore, a search strategy was developed by accessing each of the electronic databases separately.

Search statements in Boolean logic were constructed using the search terms and their synonyms, as illustrated in Table 7. The controlling connectors, OR, AND and NOT were employed to widen the search scope, to narrow it, or to eliminate a specific set of articles, respectively. With the connector, OR (e.g., governance officer OR governance facilitator), the database produced all the articles that had any of the two terminologies in them. The use of AND allowed the search to detect only those articles that had both terminologies in that database (e.g., accountability AND NHS). NOT was used to remove articles that were not required for the study. Some of the search words, such as 'accountability' and 'governance officer', were truncated with an asterisk (e.g., accountab*, governance officer*) to expand the options for related words. This further widened the scope and allowed for as many related articles as possible to be retrieved (Polit and Beck, 2018; Toronto and Remington, 2020).

The electronic literature search was limited to journal articles that were written from 1997 to date in English

language. These limits were introduced in order to streamline and focus the search on articles that are relevant. As clinical governance was introduced in the British National Health Service in 1997, it was felt that this should be the start year for the search for relevant articles. Quotation marks were used to hold phrases together, e.g., "clinical governance officer" (Table 7).

Table 7: Search strings for study

Search 1 (SI)	"Clinical governance officer*" OR "governance officer*" OR "governance facilitator*" OR "Compliance officer*" OR "compliance facilitator*" OR "quality assurance officer*" OR "quality assurance facilitator*" OR "quality improvement officer*" OR "quality improvement facilitator*" OR "quality and safety officer*" OR "risk management officer*" OR "risk management facilitator*"
Search 2 (S2)	NHS OR "National Health Service" OR "British Health Service" OR "Health service*" OR Healthcare OR "healthcare setting*" OR "healthcare system*"
Search 3 (S3)	Accountab* OR answerab* OR responsibil*
Search 4 (S4)	SI AND S2 AND S3
Search 5 (S5)	Board* OR "Trust Board*" OR "evidence-based medicine" OR "corporate governance" OR "finance governance" OR "information governance" OR "research governance"
Search 6 (S6)	(S1 AND S2 AND S3) NOT S5

Inclusion and exclusion criteria were developed as shown in Table 8. The essence of enlisting inclusion and exclusion criteria was to provide focus to the study and also to reduce bias (Toronto and Remington, 2020). These criteria determined the scope and the credibility of the study.

Articles were included for review if they met all the inclusion criteria, while they were excluded if any of the exclusion criteria existed.

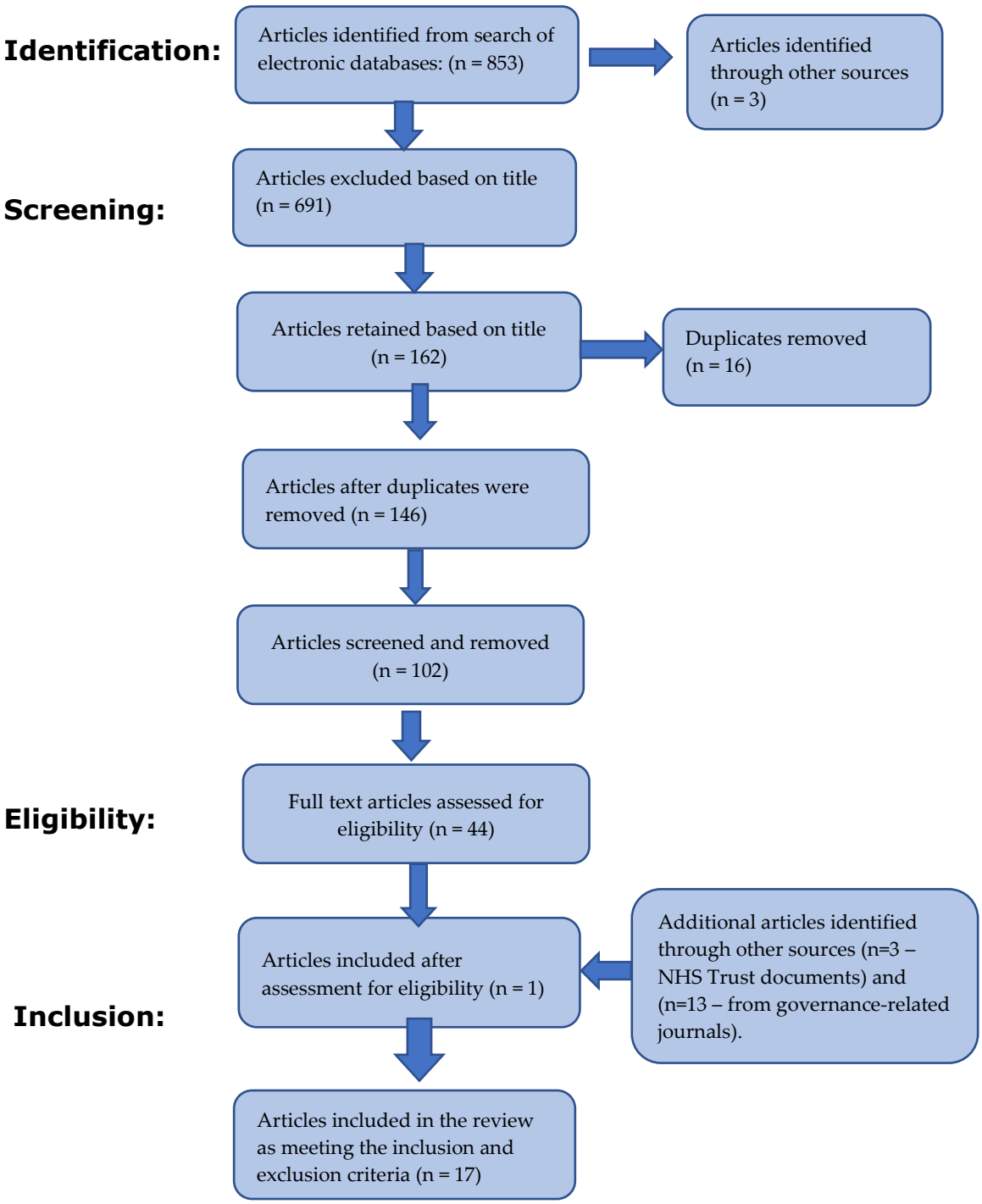
Table 8: Inclusion and exclusion criteria for literature search on governance officers working in an NHS Trust

Inclusion criteria	Exclusion criteria
The paper relates to governance officers/governance facilitators/compliance officers, etc.	The paper relates to other members of staff working in the NHS.
The paper relates to a healthcare setting where patients are treated and cared for.	The paper does not relate to a healthcare setting.
The paper relates to ensuring accountability in a clinical setting.	The paper relates to accountability in Trust Boards.
The paper relates to quality assurance/improvement	The paper relates to evidence-based medicine.
The paper relates to governance.	The paper discusses corporate, information, research or financial governance.
The paper is written in English.	The paper is written in languages other than English.
The paper was written between 1997 and 2019.	The paper was written before 1997.
The literature is published full text research articles from journals, literature from books, or position papers presenting emerging ideas and White Papers.	The literature comprises editorials, abstracts, posters, presentations or papers where full-text is not available.

There was no restriction on study designs. On handsearching the literature, it became clear that there might be additional literature that was unavailable in the search of the original databases. Therefore, I decided to run a search through Proquest and found additional literature. The process is shown in a Preferred Reporting Items for Systematic

reviews and Meta-Analysis (PRISMA), developed by Moher *et al* (2009) in Figure 2.

Figure 2: PRISMA flow chart of literature search (Adapted from Moher *et al*, 2009)



Eight databases were searched individually and a total of 853 hits were obtained from them. These hits were saved and their titles were thoroughly scrutinised in accordance with the inclusion criteria to ascertain if the articles would be relevant to the study. The majority of the articles provided information on what clinical governance is and its role in improving upon the quality of patient care. There were a lot of articles on accountability, but only a few of these were on how governance officers ensure accountability. Based on the titles, 691 articles were excluded and this left 162 articles, of which 16 were duplicates. After removing the duplicates, the number of articles was 146. The abstracts of these hits were reviewed for relevance and 102 further articles were removed. This left 44 articles whose full texts were assessed for eligibility. Only one of them met the inclusion criteria. This was the only article in the electronic search that discussed the role of clinical governance facilitators.

The search for relevant literature was supplemented with a manual search for articles on clinical governance officers. Following a review of some grey literature, an NHS Trust policy, one NHS Trust Governance strategy and one NHS Trust Clinical Audit and Quality Improvement strategy – all relating to governance officers and their role in ensuring accountability, were identified. I also reviewed some clinical governance-related journals such as *Clinical Governance: an International Journal* (which is now *International Journal of Health Governance), Journal of*

Clinical Research and Governance and *International Journal of Healthcare Quality Assurance*. Thirteen articles with information on clinical governance officers, clinical governance facilitators or quality improvement officers and how they ensure accountability were retrieved because they met the inclusion criteria. Although many of the articles had scanty information on governance officers, this brought the total number of articles that met the inclusion criteria to 17 articles. The scanty information on governance officers might be because they are a relatively new staff group within the NHS. It was not until 1997 that governance officers were employed within the NHS. Although there was scanty literature on governance officers, the urge to widen the scope of the research was resisted at this stage to stay aligned to the search question.

2.2.3.2 Data evaluation

This section of the integrative review assesses the quality of the literature that was included in the review. Table 9 shows the articles that were selected and the key findings of these articles on the role of the staff in ensuring accountability at a local level within NHS Trusts. The focus of healthcare only in the UK and not internationally, was in order to maintain address a specific goal and also to ensure completion of the study within the set time boundaries.

Table 9: Selected articles from the literature search

Title/Author	Study Population	Research Design	Key Findings	Limitations
Managing heart failure in primary care: first steps in implementing the National Service Framework/ Gnani *et al* (2004)	90 patients with heart failure were examined.	A qualitative study – review (semi-structured interviews)	Patients with heart failure were treated in line with the National Service Framework for coronary disease. In order to compare how these patients were treated, healthcare professionals and managers attended workshops and interviews to review performance. Clinical governance officers were interviewed alongside nurses and GPs. Two clinical governance officers attended a workshop on heart failure.	Not theoretical. Two GP practices. Limited generalisability. Selection bias and reporting bias.
Yes, our work really is vital; Health/ Bestic, L (2004)	Miscellaneous NHS roles, including clinical governance officers.	Newspaper article/a narrative	A newspaper article reviewed the roles of a new set of staff in the NHS. The article explained the role of the clinical governance officer as working with clinicians and managers to fulfil the governance agenda. Their average remuneration was reported as £27,879.	Limited information on the role of the governance officer.
Making clinical governance happen at team level: the Dorset experience/ Mynors-Wallis *et al* (2004)	58 portfolios were reviewed by clinical governance facilitators.	A qualitative study – a review	An NHS Trust developed a portfolio to involve clinical teams in governance activity and to monitor progress. The portfolio co-ordinator met with the clinical governance facilitator at least every six months to review progress.	Not an empirical study.
Developing large group working in clinical governance/ Wall *et al* (2006) governance.	40 people met for a 2-day event in a hotel. Clinical governance facilitators co-ordinated the process.	A qualitative review	The paper describes how clinical governance facilitators of a governance support team arranged a 2-day event in a hotel to bring about improvement in emergency care. They gathered nurses, consultants, GPs, ambulance personnel, patient groups and a Primary Care Trust at the event. The facilitators used well-	Not theoretical/empirical.

Title/Author	Study Population	Research Design	Key Findings	Limitations
			defined facilitation techniques to gain ideas about patient journeys, share ideas and put actions in place to ensure improvement to patient outcomes.	
Clinical governance – the turn of continuous improvement? /Peak *et al* (2005).	Clinical governance officers	Viewpoint article – a case study	The paper presented a model made up of three components: Accountability: The responsibility for the provision of safe and effective care. Assurance and innovation: Governance officers provide assurance of standards and they help to bring about new ways of working – through the promotion and dissemination of good practice. Roles and responsibilities have to be approved. Governance officers facilitate the delivery of governance processes. *The role of the governance officer involves innovating, promoting and facilitating clinical governance issues within a designated area. *Clinical governance officers go on ward rounds which facilitates contact with ward staff.	Subjective – not an empirical study, hence no sample size.
Talking quality/ Brown, J (2005)	Clinical governance facilitators	Viewpoint article	The paper is written by a clinical governance facilitator who describes her role. She acts as a resource and supports directorates. This is done by ensuring that the audits, risks, policies, procedures, etc. are correctly addressed. Clinical governance facilitators attend meetings such as multidisciplinary	Informal report. Not an empirical or research paper. No sample size.

Title/Author	Study Population	Research Design	Key Findings	Limitations
			sessions and governance meetings. They facilitate discussions on clinical governance and give progress reports. They are accessible to staff, and they speak on behalf of staff and patients. They facilitate change, e.g., in record-keeping. The writer states that the role of the clinical governance officer is demanding, but rewarding. She feels that she is a member of the team that is improving patient care.	
How healthy is the Annual Health Check? / Cole, J and Radnor, Z (2010)	Sample size – not applicable.	A national survey using postal questionnaires	The Annual Health Check is an annual rating that NHS Trusts were awarded based on their performance. The check measures the level of service quality. NHS Trusts were expected to be compliant with these checks. Some Trusts employed clinical governance officers to co-ordinate this process. Clinical governance officers helped to coordinate 102 questionnaires.	Not an empirical study.
Implementing a venous thromboembolism (VTE) prevention /Brockbanks *et al* (2010)	Service improvement facilitator	A qualitative study – survey	The article discusses how a service improvement facilitator in an acute NHS Trust assisted in bringing about improvement. This was done by auditing VTE risk assessments as part of a Trustwide audit.	Limited information on the roles of the participants.
Evaluation of a health visitor-led sleep and behaviour clinic/ Merrifield, R (2005)	The sample size was 28 questionnaires.	A qualitative study – a review	The paper describes how a health visitor-led sleep and behaviour clinic was evaluated. A clinical governance facilitator helped to develop a patient satisfaction questionnaire and also collate the results of an audit. The evaluation	Small sample size. Reporting bias from parents' reports. No Control.

Title/Author	Study Population	Research Design	Key Findings	Limitations
			audited clinic activities, effectiveness of the intervention and client satisfaction.	Response rate = 53.8%.
How to set up a medical referrers system/ Ward, E (2009)	Clinical governance facilitators	A qualitative study – a service improvement	The clinical governance facilitator reviewed local policies and after a discussion at a governance meeting, it was agreed that a new approach to non-medical referrers should be initiated. The governance facilitator liaised with the matron and the clinical services manager to set up a new system.	Qualitative study – not an empirical study.
A multicentre randomised controlled trial of reciprocal lung cancer peer review and supported quality improvement: results from the improving lung cancer outcomes project/ Russell *et al* (2014)	162 NHS Trusts	A randomised control trial of peer review and supported quality improvements	A multicentre randomised controlled trial of a lung cancer peer review was carried out to assess the impact of peer view visits, quality improvement and collaborative working on lung cancer outcomes. The quality improvement facilitator guided staff on the implementation of the quality improvement plan and ensured that the staff were focussed. The facilitator also provided the template for the plan and co-ordinated the visits. Support was provided via e-mails, telephone calls and follow-up visits.	Limited information on the roles of the participants.

Title/Author	Study Population	Research Design	Key Findings	Limitations
General practitioners' assessment of, and treatment decisions regarding common mental disorder in older adults: thematic analysis of interview data/ Strachan *et al* (2014)	9 GPs	A review (Group interviews)	Nine GPs took part in interviews to examine their assessment of mental disorder in older patients and also their treatment decisions. The clinical governance facilitator provided advice with ethics by reviewing the research proposal for the study.	Small sample size – not generalisable. Selection bias.
Governance Strategy/NHS Trust H (2018).	Clinical governance officers	Grey literature – Governance Strategy	The document describes activities that are undertaken within the Governance Department. Governance officers coordinate and facilitate the delivery of governance processes: Risk and Incident Management, Clinical Audit. Governance officers also support, maintain and help to improve the delivery of healthcare services/improve patient care and they provide assurance of the quality of care. Other areas of responsibility are: CQC, External Reviews, Information Governance, Claims, NICE Guidance, National Guidance. They also attend directorate governance meetings.	Substandard quality.
Implementing a non-steroidal anti-inflammatory drugs communication bundle in remote and rural pharmacies and dispensing practices/ Morrison *et al* (2018)	Quality improvement facilitator	A qualitative study – a review. Quality improvement report	The paper describes how a non-steroidal anti-inflammatory drug bundle was implemented in rural and remote pharmacies in Scotland. It explains how a quality improvement facilitator assisted with collating the data for the audits. They visited remote sites to provide support for the implementation of the bundle.	Limited information. The paper does not clearly state the aim.

Title/Author	Study Population	Research Design	Key Findings	Limitations
Operational Policy for Risk Management/ NHS Trust (2019a)	Clinical governance officers	Grey literature – Trustwide operational policy	The policy highlights the steps for governance officers to coordinate and facilitate the delivery of governance processes.	Substandard quality. Not an empirical study – no sample size.
Clinical Audit and Quality Improvement Strategy/ NHS Trust H (2019b)	Clinical governance officers	Grey literature – strategy for clinical audit	Governance officers facilitate and support the implementation of the clinical audit strategy. They promote effective clinical audit at all levels and report areas of non-compliance.	Substandard quality. Not an empirical study. No sample size.
Impetus to change: a multi-site qualitative exploration of the national audit of dementia/ Sykes *et al* (2020)	Six hospitals were involved in the exploration.	A qualitative exploration (32 semi-structured interviews/documentary analysis/observation)	During a review of the national audit of dementia, the clinical governance facilitator and audit facilitator took part in interviews. The audit facilitator talked about audits stating that high risks are escalated to the Board.	Small sample size – not generalisable and it is subject to bias.

2.2.3.3 Study characteristics/Evaluation

In the NHS, staff employed to ensure accountability are identified by different titles: clinical governance officer, clinical governance facilitator, service improvement facilitator, quality improvement facilitator, clinical audit facilitator, etc. The variety in titles was reflected in the available literature. Following the search, seventeen articles were selected. They provided different levels of information on how the staff ensure accountability within the NHS.

In many cases, the information was scanty. A majority of the articles related to clinical governance facilitators who gave specialist support to clinicians. The articles tended to be superficial and they provided no information on the background of the governance officers/facilitators. Many of the articles provided insufficient information on the roles of the staff involved. It was not clear if the governance officers/facilitators were nurses, doctors, etc. If they had clinical backgrounds, this could change the status quo re: power dynamics, interactions and engagement with their clinical colleagues.

It was impossible to use appraisal tools such as are available in the Critical Appraisal Skills Programme (CASP) or the Mixed Methods Appraisal Tool (MMAT), because the articles were not all empirical. Also, appraising these articles together would be complex because of their miscellaneous nature. Whittemore and Knafl (2005) do not emphasise the use of appraisal tools for integrative reviews, hence the articles were

evaluated without appraisal tools. They were appraised based on how well bias was addressed within that cohort of articles.

Ten of the selected articles were reviews (Gnani, 2004; Mynors-Wallis *et al,* 2004; Merrifield, 2005; Wall *et al*, 2006; Ward, 2009; Brockbanks *et al*, 2010; Cole and Radnor, 2010; Strachan *et al*, 2014; Morrison *et al*, 2018; Sykes *et al*, 2020). Three articles were NHS grey literature: (NHS Trust H, 2018; NHS Trust H, 2019a; NHS Trust H, 2019b). This grey literature comprised internal documents that were written by managers in the NHS Trust under study and approved by Trust Management Committees. One article was a randomised controlled trial (Russell *et al,* 2014); two were viewpoints: a case study (Peak *et al,* 2005) and one that was written by a clinical governance facilitator (Brown, 2005). A newspaper article (Bestic, 2004) discussed some new roles in the NHS, one of which was the role of the governance officer.

Researchers tend to place less value on anecdotal articles because of the danger of their being over-subjective. Some would argue that the views that are expressed by the authors create a potential for bias and reduce the credibility of the study. Notwithstanding, removing them from the literature pool could potentially cause bias. Furthermore, those study designs that are seemingly lower down the hierarchy are possibly best-suited to answering some research questions (Toronto and Remington, 2020). The articles were informative in showing how accountability was ensured by this group of NHS staff.

The articles were written between 2004 and 2020 and they are of varying quality. Some were well-referenced and well-illustrated with tables, figures and charts, e.g., Russell *et al*, 2014. The titles of these articles reflected their aims. Six articles (Brown, 2005; Brockbanks *et al*, 2010; Morrison *et al*, 2018; NHS Trust H, 2018; NHS Trust 2019b; Sykes *et al*, 2020) reported on audit-related activities. Three articles (Gnani, 2004; Wall *et al*, 2006; Russell *et al,* 2014) reported on how a quality improvement facilitator, some clinical governance facilitators and governance officers co-ordinated peer review visits, arranged a 2-day event and participated in interviews and workshops, respectively, to improve service.

The randomised controlled trial (Russell *et al*, 2014) was of good quality; it was peer-reviewed. The sample size was sufficient and samples were collected in a blinded fashion, even though the groups were comparable at the start. There was minimal loss to follow-up and the groups were equal at the end of the trial. Although the trial stimulated activity, only minor improvement was noticed. The response rate was 66% for the trial. Notwithstanding, the risk of bias is low.

The qualitative studies formed the majority of articles (n=11). The data collection methods comprised semi-structured interviews, a case study, viewpoints and questionnaires. Some of the qualitative studies had quotes for further illustration. Articles such as Gnani *et al* (2004) and Strachan *et al* (2014) could have selection bias due to the limited number

of GP practices and small sample sizes, respectively. In addition, the possibility of reporting bias was highlighted in Gnani *et al* (2004) – due to the potential lack of clarity from using the telephone; and Merrifield (2005) – as a result of possible variation of parents' reports compared to actual activity. The response rate for the latter article was 53.8% and there was no Control, which would have given a better insight. Merrifield (2005) was the only study that mentioned a theoretical framework – behavioural therapy. Most articles could have benefitted from reference to theoretical frameworks.

The only mixed methods study was an exploration of the national audit of dementia (Sykes *et al*, 2020). It comprised 32 semi-structured interviews, documentary analysis (n=39) and observations (n=36). The research question for this article is not clear. However, there was coherence between the qualitative data sources, the data collection, analysis and discussion. The study was amply supported with quotes. There is a succinct statement expressing why the mixed methods approach has been used for the study. The methods are all integrated and the group took into consideration the similarities and the differences across the methods (Hong *et al*, 2018).

In the Dorset Healthcare NHS Trust, clinical governance facilitators helped to monitor the use of portfolios with which clinical governance activity was monitored and recorded (Mynors-Wallis *et al,* 2004). The article showed governance officers and facilitators with specialist roles

working closely with the clinicians to bring about improvement, thereby enhancing engagement.

The viewpoint article (Peak *et al*, 2005) promotes a model of continuous quality improvement at the Royal Liverpool Children's NHS Trust. The model shows the roles and responsibilities that are associated with clinical governance and measurable outcomes. It is based upon the three dimensions of accountability, assurance and innovation – a model which is transferable to other Trusts. The article is clearly written, easy to read and logically analysed, with the aim of the article situated at the beginning. No research findings are reported by the six authors who work in the Children's NHS Trust. There is also no discussion regarding whether or not approval for the study had been obtained by the Trust.

2.2.3.4 Data analysis

The data analysis stage involved reviewing the information across the chosen articles and then coding and classifying them into themes and subthemes (Cooper, 1998; Whittemore and Knafl, 2005). Data analysis consists of five stages: data reduction, data display, data comparison, conclusion drawing and verification (Miles *et al*, 2014; Parahoo, 2014; Patton, 2015; Flick, 2018; Gibbs, 2018).

Data reduction

Data reduction involved selecting, simplifying, summarising, logically sorting out and classifying the data such that it would be easier to manage. Data reduction also enabled the final conclusions to be readily attained. It included coding and sorting out themes, so that the data could be analysed sequentially based on the nature of the articles. The initial classification, for instance, was the type of source. Data was continuously reduced until the final report was completed.

Data display

This involved showing the data in an organised and immediately accessible form to enhance presentation and comparison. Categories were used to enhance the presentation in table form, as shown in Table 9 on page 49.

Data comparison, conclusion and verification

The data comparison stage involved identifying and grouping similar variables together to form themes. This is also the stage where any meaningful clusters were initially identified. This stage of data comparison was difficult because of the diverse nature of the articles. The articles are not research studies and it was an arduous task critiquing them or forming themes. The two themes below were identified:

- Ensuring accountability – role expectations
- Ensuring accountability – actual performance

The conclusion stage involved further analysis of each subgroup in order to draw out conclusions for each one. These were continuously revised to include as much data as possible. The subgroup conclusions were cross-checked for accuracy and credibility. Once verified, the components from all the conclusions were synthesised to give a meaningful depiction of the subject matter.

2.2.3.5 Results

The papers relate to NHS Trusts and many of them complement one another in explaining the roles of the individuals who are involved in ensuring local accountability in an NHS Trust. Although they all relate to clinical governance and ensuring accountability, the articles were divided into two groups based on what has been advised as the ideal method of ensuring accountability, i.e., role expectations and the actual performance that is undertaken in these NHS Trusts.

The results will be discussed using two themes, as explained earlier.

Ensuring accountability – role expectations

The available literature highlights how clinical governance-related activities should be undertaken within some Trusts, i.e., the role expectations. Four articles, a viewpoint (Peak *et al,* 2005) and NHS grey literature (Trust H, 2018; NHS Trust H, 2019a and NHS Trust H, 2019b), provided information on implementing good governance and ensuring accountability within NHS Trusts.

The article by Peak *et al* (2005) proposes a model for clinical governance that identifies accountability, innovation and assurance as important components. The NHS Trust grey literature comprise a clinical audit and quality improvement strategy, a governance strategy and a Trust policy. These documents highlight the direction for moving the clinical governance agenda forward. They lay down the foundation for the delivery of high-quality patient care and they propose the actions that will generate the expected results. The information in the articles is important as it provides the role expectations and it also reduces duplication of responsibilities and gaps. The roles that are described include innovating, promoting and facilitating clinical governance-related issues within a designated area.

Peak *et al* (2005) state that governance officers encourage good practice and they also coordinate and facilitate the delivery of governance processes at the local level. The model that these authors present focusses on:

- Assurance: providing assurance to the Trust Board and the relevant stakeholders that the expected standards have been attained
- Accountability: being responsible for the delivery of safe and responsive care
- Innovation: developing new ways of working for improvement.

This model also considers the expected outcomes and explicit roles and responsibilities for clinical governance facilitators. The model is illustrated

by a ‘governance cycle’ and it seeks to promote continuous quality improvement. It is important that there is transparent communication with stakeholders of the organisation and that staff are aware of what a successful outcome should entail. This would avoid ambiguity, uncertainty and tension. For a successful outcome, there should be a robust reporting system in place. Peak *et al* (2005) describe the role of governance facilitators in the ‘promotion, innovation and facilitation’ of clinical governance issues. This is further implemented by having ward rounds where important issues are addressed with frontline staff. Issues arising from these ward rounds are escalated.

The papers had a shared view of the governance officer role which showed some conformity. This was that the governance officer facilitates the delivery of governance processes at a local level. The Risk Management Policy (Trust H, 2019a) clearly describes the roles. There is glossary at the beginning of the document to clarify some of the terms. In addition, the reference list at the end of the policy is a reflection that other sources had been considered while writing. Although they have no glossaries, the Trust strategies give detailed descriptions of expected roles and responsibilities.

The papers collectively indicate that governance officers/facilitators have a wide range of responsibilities and interactions. They all describe similar staff responsibilities. Governance officers were reported as working closely with the directorate management teams and clinicians in order to

provide and address Clinical Audit, CQC Visits, External Reviews, Incident Management, Information Governance, Risk Management, NICE Guidance, National Guidance and general governance management issues. There is a positive correlation between the number of activities that are undertaken and the frequency of the interactions (Buchanan and Huczynski, 2017).

The role of governance officers is to facilitate and support the implementation of the Clinical Audit and Quality Improvement strategy (Trust H, 2019b) by:

- Working with the audit convenor to generate a realistic audit plan
- Facilitating clinical audit projects within the directorates
- Ensuring the production of a robust report and action plan
- Promoting, supporting and providing training on the use of the clinical audit database.

The governance strategy is a robust document which shows the governance structure and the flow of communication. It also includes information on the vision, values and objectives of the Trust. It provides an in-depth description of the governance workstreams, including the objectives and responsibilities. In addition, terms of reference for meetings are included.

Ensuring accountability – actual performance

This section discusses the articles that were selected in the review which describe the activities that are actually being carried out in order to ensure accountability. The role of the governance officer was described as working with clinicians and managers to fulfil the governance agenda (Bestic, 2004).

Brown (2005); Brockbanks *et al* (2010); Cole and Radnor (2010); Morrison *et al* (2018); NHS Trust H (2018); NHS Trust (2019b) and Sykes *et al* (2020) report how clinical audit brought about improvements in some NHS Trusts. These activities include auditing venous thromboembolism (VTE) assessments, collating audit results and ensuring the audit loops were closed.

Clinical governance facilitators in some Trusts were employed to co-ordinate Annual Health Checks across Divisions (Cole and Radnor, 2010). These are initiatives which reflect the performance of organisations. Audit was one of the aspects on which the Annual Health Checks were based. Other audit-related activities were self-assessments and external reviews. Audits were also undertaken to bring about an improvement in performance with VTE and to ensure compliance to a non-steroidal anti-inflammatory drugs communication bundle (Brockbanks *et al,* 2010; Morrison *et al*, 2018). A common limitation across some of the articles was the small sample size which impacts on generalisability. There was

insufficient information on the roles of the staff and some articles did not have specific aims.

Quality improvement facilitators supported service improvement in a multicentre randomised controlled trial involving peer review visits (Russell *et al*, 2014). A total of 31 Trusts participated in these visits which were set up following results of a lung cancer audit that showed high variations in outcomes. The quality improvement facilitators provided the templates for the plans and introduced the model. They supported the staff via different modes of communication – e-mails, telephone calls and face-to-face interviews. The study by Morrison *et al* (2018) reported how quality improvement facilitators worked with a team to implement a non-steroidal anti-inflammatory drugs communication bundle in remote areas. They visited the different sites to show support and they also collated data for some audits.

Clinical governance facilitators in an NHS Trust in Dorset participated in the development of a portfolio which enabled clinicians to get involved with clinical audit and monitor progress (Mynors-Wallis *et al*, 2004). The governance facilitator met with the portfolio co-ordinator every six months. In addition, Wall *et al* (2006) reported how governance facilitators in a Trust arranged a 2-day large group working event where clinicians from various disciplines came together to share ideas on improving patient outcomes. Other roles of clinical governance officers included ensuring that risks, policies and procedures are correctly

addressed. They also attended multidisciplinary meetings and governance meetings where they facilitated discussions and gave progress reports. In addition, they were readily accessible to and supported staff and also helped to facilitate change (Brown, 2005). While acknowledging that the role of the clinical governance officer is demanding, but rewarding, Brown (2005) reported that she felt like a useful member of the team.

2.2.4 Further literature review

2.2.4.1 Identification of the problem

It became more apparent when reviewing the findings, that there may be synergy with other roles within the NHS regarding role ambiguity, role overload and role conflict. It was felt that broadening the scope of the literature review would provide insights into other roles within the NHS where staff experienced role ambiguity, role overload and role conflict. This would also strengthen discussions of the findings. A further literature search was, therefore, undertaken to identify roles within the NHS where this was experienced. This is important because, role ambiguity, for instance, could possibly impact negatively on job satisfaction. It could lead to stress, anxiety and a reduction in effectiveness.

The keywords that were used for the search are listed in Table 10. The non-medical staff would comprise roles such as pharmacist,

radiographer, manager, etc. However, due to the number of roles within the NHS, it was not apt to list specific roles.

2.2.4.2 Literature search

Table 10: List of keywords used

Role-related terms	National Health Service	Roles in the NHS
Role ambiguity	NHS	Staff
Role overload	British Health Service*	Employee*
Role conflict	Health Service*	Nurse*
Role clarity		Doctor*
		Clinician*
		Non-clinician*
		Medical staff
		Non-medical staff

The inclusion and exclusion criteria that were used for the literature search are listed in Table 11.

Table 11: Inclusion and exclusion criteria for literature search on role ambiguity, role overload and role conflict

Inclusion criteria	Exclusion criteria
The papers relate to role ambiguity, role overload and role conflict within the NHS.	The papers relate to other roles outside the NHS.
The papers relate to healthcare settings in the United Kingdom.	The papers relate to healthcare settings outside the United Kingdom.
The papers are written in English.	The papers are written in languages other than English.
The papers were written from 2000 to date.	The papers were written before 2000.
The papers are published articles in peer-reviewed journals, books.	The papers are editorials, abstracts, posters or papers where full-text is not available.

The initial retrieval of articles (n = 336) was done using the keywords. The PRISMA flowchart in Figure 3 shows how the articles were identified. The retrieved titles and abstracts were considered and 272 of them were removed for not meeting the inclusion criteria. The number of duplicates that were removed was 23 duplicates.

The remaining articles were reviewed again for eligibility using their abstracts and 30 articles were selected. On reading the full texts, 26 articles were finally chosen for review. All articles that related to role ambiguity, role overload and role conflict within the NHS were retrieved. The groups of staff that were identified in the available literature,

although not used as specific key words/synonyms, included staff groups such as advanced nurse practitioners, mental health workers and nurse consultants, all working within the NHS. The majority of the literature were for mental health workers (n = 8). Most of the articles consisted of qualitative studies which used data collection methods which included semi-structured interviews, questionnaires and surveys.

Figure 3: PRISMA flowchart for further literature review

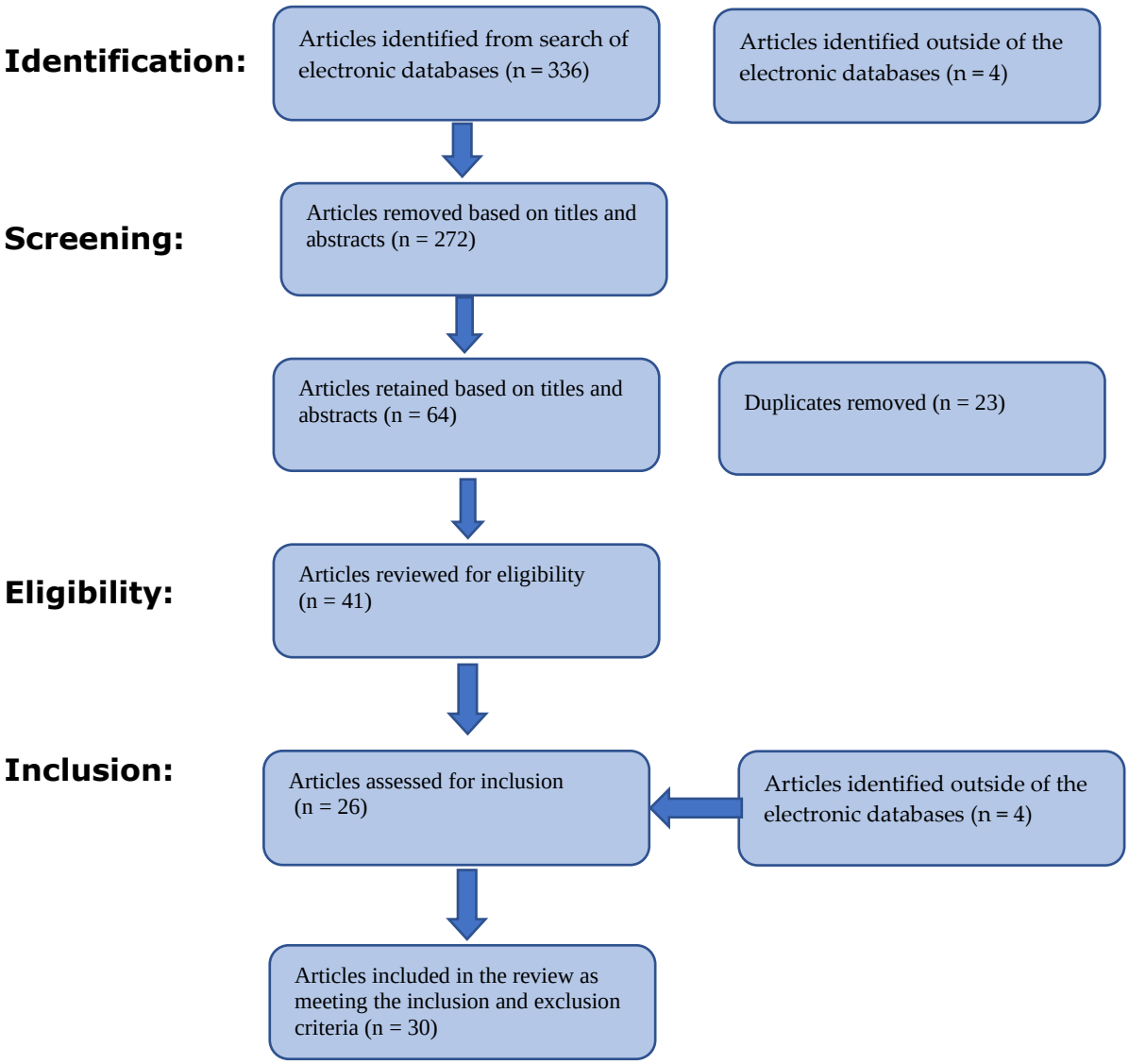


Table 12 shows the summary table of the articles that were selected.

Table 12: Selected articles for further literature review

Title/Author	Study population	Research design/Data collection method	Key Findings	Limitations
Being an effective nurse consultant in the English National Health Service: what does it take? A study of consultants specializing in safeguarding/Franks and Howarth (2012)	Four nurse consultants	Qualitative study/Semi-structured interviews	The study explored the role of nurse consultants who specialise in safeguarding. Findings showed that the role of the nurse consultant is new and issues such as role ambiguity, role overload and challenging inter-professional relationships are experienced.	A small sample size from one Trust. This could impact on generalisability.
The influence of organisational climate on care of patients with schizophrenia: a qualitative analysis of healthcare professionals' views/Sutton *et al* (2016)	Sample size: 10 doctors, nurses, pharmacists in mental health outpatient services	Qualitative study/Semi-structured interviews, with 10 healthcare professionals	The healthcare professionals working in a mental healthcare clinic spoke of the need for role clarification. There was a lack of understanding of roles within the team which led to considerable role ambiguity. Boundaries were not clear.	Small sample size from one Trust.
Clinical nurse specialists in palliative care. Part 3. Issues for the Macmillan Nurse role /Seymour *et al* (2002)	44 palliative care nurses and 47 key colleagues across 12 services.	Qualitative study/Semi-structured interviews	The study showed that new policies led to the creation of roles which caused role ambiguity and role conflict. There was a lack of clarity between Macmillan nurses and	The study could benefit from triangulation.

Title/Author	Study population	Research design/Data collection method	Key Findings	Limitations
			their managers about the focus of their role.	
Stress and burnout in community mental health nursing: a review of the literature/Edwards *et al* (2000)	A literature review of 17 articles on Community mental health nurses	A literature review.	A review of stress and burnout in community mental health teams showed increasing levels of stress as a result of role overload, role conflict and inadequate resources.	Small sample size which is not representative.
The importance of role sending in the sensemaking of change agent roles/Tucker *et al* (2015)	82 middle managers	Case study design/82 interviews; document analysis and field observation	The study explored the effects of a lack of role-sending. It showed the effects that sending inadequate expectations about a new role can have on behaviour. Where there is a lot of flexibility, the responsible staff develop ambiguous roles.	The study covers one site – little basis for generalisation of the results.
Primary care mental health workers: role expectations, conflict and ambiguity/Bower *et al* (2004)	46 managers and clinicians from primary care and specialist mental health services	Case study design/Semi-structured interviews	The case study design was carried out to explore staff expectations on the new role of primary care mental health workers. The role brought about role ambiguity. Staff had expectations that the role would address the gaps in service provision, but it was related to working with clients. This also created role conflict.	Issues of generalisability and the staff not being representative of the population.

Title/Author	Study population	Research design/Data collection method	Key Findings	Limitations
The role and potential contribution of clinical research nurses to clinical trials/Spilsbury *et al* (2008)	Clinical research nurses	Qualitative study/Focus group and field notes	Nurses have been working on clinical research due to the increase in research trials. Challenges of the role included role conflict, as they were both researchers and nurses.	Some participants might not want to voice their thoughts on sensitive issues.
An evaluation of the Leading an Empowered Organisation programme/Cooper, S (2003)	Nurses	Prospective case study	At a leadership programme, nurses reported role conflict between their nursing and leadership roles.	The data is not generalisable.
The role of the lecturer practitioner/Leigh *et al* (2005)	Two lecturer practitioners and stakeholders from education and practice.	Qualitative study/Diaries and semi-structured interviews	The joint appointment role of the lecturer practitioner highlighted an initial lack of clarity. This was reported as causing role conflict. There were issues with identifying specific roles and responsibilities.	Not generalisable. The benefits of the role were not explored.
Experiences of occupational health doctors and nurses about the role of physiotherapists in occupational health rehabilitation: a qualitative study/Chetty, L (2020)	Occupational health physiotherapists, including two occupational health doctors and 12 nurses.	Qualitative study/13 semi-structured interviews	The study was undertaken to explore the experiences of occupational health doctors and nurses about the role of physiotherapy in occupational health rehabilitation. A participant reported role ambiguity – there was no structure as to who does what. Roles were blurred. There were numerous roles which ranged	The study was restricted to two groups in two NHS hospitals.

Title/Author	Study population	Research design/Data collection method	Key Findings	Limitations
			from clinical to organisational and each group's role was unclear.	
Mental Health Workers' Perception of Role Self-Efficacy and the Organisational Climate Regarding the Ethos of Recovery/MacAteer *et al* (2016)	Sample size was 110 mental health workers, social workers, nurses, occupational therapists	Quantitative methods/survey – using questionnaires	The study explored the relationship between self-efficacy, organisational climate and resilience, ambiguity and conflict. The findings were that there is increased role ambiguity and role conflict due to the increased number of mental health workers. This is also due to increased demands and resources. As the organisational climate improved, role ambiguity and role conflict reduced.	Small sample size, including small size of occupational therapists.
Exploring issues of maternity care assistant role boundaries/Willocks, K (2011)	Maternity care assistants	Qualitative studies/survey	The results of a survey identified role conflict as one of the challenges of the role of the maternity care assistant. Also, there was deskilling of staff as a result of a generalised role.	This does not comprise empirical data. Small sample size.
Third year student nurses' perception of the role and impact of the clinical nurse specialists: A multi-centred	220 student nurses	Self-report instrument	The study was undertaken to examine the views of student nurses on clinical nurse specialists. The students	A short survey instrument was used.

Title/Author	Study population	Research design/Data collection method	Key Findings	Limitations
descriptive study/Jack *et al* (2004)			acknowledged improved patient care. However, they felt role conflict was an issue.	
A world apart: How occupational health therapists, nurses and care managers perceive each other in acute healthcare /Atwal, A (2002)	Occupational therapists, nurses and care managers	Qualitative study/Interviews	The interviews revealed role confusion amongst the three staff groups. The paper highlighted the need for role clarity to avoid role ambiguity.	This does not comprise of empirical data. Small sample size.
The challenges and conflicts of facilitating learning in practice; the experiences of two clinical nurse educators/Brennan, A and Hutt, R (2001)	Clinical nurse educators	A descriptive paper	The papers discussed the experiences of two clinical educators. These staff have joint roles of nursing and teaching which cause role conflict. The paper highlighted the need to address this role in view of the expected increase in the number of nurse trainees.	Not an empirical study.
An examination of senior nursing roles: challenges for the NHS/Williams *et al* (2001)	Senior nurses: 14 ward managers and 25 senior nurses	Qualitative study/Focus groups and postal questionnaires	The participants identified role conflict as one of the issues.	Bias due to convenience sample.
Supporting students in practice/Manning *et al* (2008)	Clinical support nurses	Qualitative study/Focus groups and telephone interviews	The clinical support nurses had dual roles of teaching and clinical activity. Hence, they experienced both role overload and role conflict.	This does not comprise of empirical data. Limited sample size.

Title/Author	Study population	Research design/Data collection method	Key Findings	Limitations
Moving domains: radiographers as managers in NHS/Forbes, T and Prime, N (2000)	25 radiographer managers	Qualitative study/Semi-structured interviews	The radiographer managers experienced conflicts between their roles as managers and professionals. The change in their role was accompanied by tension. However, they were able to cope.	This does not comprise of empirical data. Small sample size.
Tensions within management roles in healthcare organisations/Scott, A and Timmons, S (2017)	Ward leaders	Qualitative study/In-depth interviews	The role of the ward leader is important if the quality of care that is provided to patients in the wards is to improve. The paper reported that ward leaders had to strike a balance between nursing and health service management.	This does not comprise of empirical data. Small sample size.
Is work stress in palliative care nurses a cause for concern? A literature review/Peters *et al* (2012)	Palliative care nurses	Literature review	Role conflict was a common source of stress for the palliative care nurses. The review showed that high workload was a common source of stress for community -based palliative care nurses. The nurses experienced busy periods with workloads that are less manageable.	This does not comprise of empirical data. Small sample size.

Title/Author	Study population	Research design/Data collection method	Key Findings	Limitations
Role of the mental health nurse towards physical healthcare in serious mental illness: an integrative review of 10 years of UK literature/Blythe, J and White, J (2012)	Mental health nurses	Integrative literature review of 9 articles	The literature review highlighted that mental health nurses did not have adequate training. As a result, their role was characterised by role ambiguity.	This does not comprise of empirical data. Small sample size.
Mental health nurse independent prescribing: what are nurse prescribers' views of the barriers to implementation? /Ross, J D and Kettles, A M (2012)	33 mental health nurses completed a questionnaire and 12 mental health nurses took part in a focus group.	Pilot study/Questionnaires and focus group	Role conflict was identified as one of the barriers affecting the role of mental health nurses. The results also showed that the mental health nurses took on a lot of responsibility and accountability which was not acknowledged.	Small sample size.
Attitudes of paediatric intensive care nurses to development of a nurse practitioner role for critical care transport/Davies *et al* (2011)	21 intensive care nurses	Qualitative study/ Questionnaires	The paper highlighted role ambiguity, role division and role boundaries as part of the nurses' role. When the questionnaires were distributed for a second survey, there was some improvement.	Small sample size.
Exploring new advanced practice roles in community nursing: a critique/Aranda, K and Jones, A (2008)	A total of 112 research articles involving community matrons, consultant nurses and	A literature review	The key findings were that advanced nurse practitioners experience role ambiguity as they try to embrace new identities.	Not empirical data.

Title/Author	Study population	Research design/Data collection method	Key Findings	Limitations
	advanced nurse practitioners			
Working with the team: strategies employed by hospital cancer nurse specialists to implement their role/Willard, C and Luker, K (2007)	29 cancer nurse specialists from 5 hospitals	Grounded theory design/ Observation and semi-structured interviews	The cancer nurse specialist role was developed in order to reduce costs. Role ambiguity and role conflict were reported.	The study is not generalisable.
How newly qualified health nurses perceive their role/ Rungapadiachy *et al (*2006)	11 mental health nurses	Qualitative study/Semi-structured interviews	Findings were taken over a 6-month period – before and post registration. It showed that the role of the mental health nurses was ambiguous because they had multiple roles to address. The results after registration were not different from before registration.	Small sample size.
Perspectives on clinical leadership: a qualitative study exploring the views of senior healthcare leaders in the UK/ Nicol *et al* (2014)	Twenty senior healthcare leaders	Qualitative study/Semi-structured interviews	Senior healthcare leaders who participated in a study felt that the term 'clinical leadership' was ambiguous. They also felt that some registrars were 'happy to work in ambiguity'.	Limited sample size.

Title/Author	Study population	Research design/Data collection method	Key Findings	Limitations
Newspaper article: Doctors call for occupational health service for NHS staff/ www.personneltoday.com/2017	Doctors and all NHS staff	Survey	The British Medical Association stated that role overload was experienced by doctors and called for a review into burnout, fatigue, low morale and stress. A survey showed that more than half of GPs suffered from work-related stress which was caused by lack of resources despite rising patient demand.	Very limited information.
Extended roles and the dietitian: community adult enteral tube care/Stanley, W and Borthwick, A M (2013)	Six dietitians specialising in home enteral tube feeding	Qualitative study/Six semi-structured interviews	Changes in healthcare brought about extensions in role boundaries for dietitians. The study highlighted the importance of role flexibility, even though there are issues around role boundary conflict.	Small sample size.
The impact of NHS change processes on art therapists working in LD services/Ashby, E (2020)	15 art therapists employed by NHS Trusts	Qualitative study/Interviews	The study explored the impact that art therapists in the NHS have on people with learning disabilities. The findings showed that change had brought about increased workload which caused stress, leading to burnout. Staff had anxiety levels and emotional exhaustion which affected their health and well-being. There	The results of the study were based mainly on interviews. The study could have benefited by triangulation.

Title/Author	Study population	Research design/Data collection method	Key Findings	Limitations
			was also a lack of clarity as to what the team should be doing.	
Revisiting job satisfaction and burnout in Community Mental Health Teams/Onyett, S (2011)	Mental health teams	A literature review	The literature highlighted that role overload and role conflict caused high levels of stress and exhaustion. However, there was no evidence of a decline in morale.	Not empirical data.

2.2.4.3 Data analysis: analysing the literature

The articles were qualitative and they were a combination of literature reviews, case studies and surveys. Fifteen of them related solely to nurses; six related to mental health workers, some of which included nurses; four articles related to doctors. Five of the articles were about miscellaneous roles which included art therapists, dietitians, radiographer managers, lecturer practitioners and middle managers. Data collection methods included in-depth and semi-structured interviews, focus groups, document analysis and questionnaires. Even though the inclusion timeline was placed at 2000, some of the articles were recent. The main theme across the articles was role ambiguity.

2.2.4.4 Presentation of results: synthesising the results

A synthesis of the findings is provided below, according to the staff groups that experienced role ambiguity, role overload and role conflict.

Doctors

Four articles relating to doctors were included in this review (Nicol *et al*, 2014; Sutton *et al*, 2016; Chetty, 2020; www.personneltoday). They all reported role ambiguity, role overload or role conflict in doctors. Nicol *et al* (2014) carried out a qualitative study on the perspectives of 20 senior healthcare leaders in the UK who had clinical leadership roles.

In the study, the healthcare leaders highlighted two dilemmas relating to ambiguity that they were faced with. The first dilemma relates to the ambiguity of the term 'clinical leadership', while the second relates to ambiguity within the role of the healthcare leaders. Clinical leadership was said to mean 'too many things to too many people' and the healthcare leaders felt that there was a need for some clarification. Some older doctors (mainly consultants) still resented the managers for taking over the leadership of the NHS some years back.

A participant-observer study by Lewis (2012) stressed that medical engagement in management roles was important as doctors were familiar with the demands of the health service. This might also impact positively on how the consultants engage with governance, i.e., how they fit into the governance structure. It is important for clinicians and managers to work in partnership in order to optimise their expertise and enhance patient care. The respondents in this study felt that changes within the NHS workforce had made opportunities available to clinicians. This led to a cultural change within the profession. Clinicians who were invited to take on managerial, leadership and strategic roles experienced role ambiguity. Junior doctors, such as specialty registrars, had been trained to take on leadership roles which included managing target-related issues. As a result, these junior doctors were comfortable with managerial roles (Nicol *et al,* 2014).

A survey carried out on about 2,000 general practitioners (GPs) in the NHS exposed a 'workload crisis'. The survey showed that more than half of them suffered from work-related stress which was caused by rising patient demand in an environment that is starved of resources (www.personneltoday). If the staff group that cares for patients suffers from role overload, this could impact negatively on the quality of care and treatment that is provided to the patients. Role overload causes anxiety, stress, fatigue and low morale. As GPs are at the centre of the health system, it is important to safeguard their health in order to protect the health of the populace.

Findings of doctors and nurses working with a team of physiotherapists revealed that role overload and role ambiguity were issues to be addressed (Chetty, 2020). The responsibilities of occupational health physiotherapists were reported to range from clinical to organisational. Role boundaries between doctors, nurses and the physiotherapists were also blurred and this led to role ambiguity. Staff had to be constantly reminded about the role of the physiotherapist within the team.

Mental health workers

The continuous change processes within the NHS require new roles to be developed. This is particularly important in the mental health sector where there is a burgeoning demand for services within a shrinking pool of resources. New roles which are usually cheaper are developed. Eight articles relating to staff working in mental healthcare settings were

identified (Edwards *et al*, 2000; Bower *et al,* 2004; Rungapadiachy *et al*, 2006; Onyett, 2011; Blythe and White, 2012; Ross and Kettles, 2012; MacAteer *et al*, 2016; Sutton *et al*, 2016). Some staff titles overlap across the themes, for instance, doctors working in mental healthcare settings.

In a case study on primary care mental health workers, Bower *et al* (2004) provided three main roles – client work, practice teamwork and networking. In line with role theory, role-sets of mental health workers are general practitioners, clinical psychologists, counsellors, etc. Bower *et al* (2004) explain that role expectations of their role-set determine the standards by which the mental health workers are evaluated. The role is still evolving and the literature provides reasons why healthcare professionals who work in mental health settings experience a high amount of role ambiguity, role overload and role conflict:

- The number and diversity of the patients that they work with.
- The number of professional groups that interact with the patients in order to bring about recovery.

Mental health disciplinary teams are made up of numerous professional groups with a variety of disciplines, each with their own ideologies, work styles, perspectives of service and professional stereotypes (Edwards *et al*, 2000; Bower *et al*, 2004; MacAteer *et al,* 2016). Role ambiguity could possibly be linked with issues of power and authority within the role.

Using the case study, Bower *et al* (2004) reported how role conflict could arise from unfulfilled role expectations. In the organisation of study, the

roles that were proposed were client-focused. However, the expectations of the staff were that the new role will fill in gaps in the current role. This was not fulfilled and it led to gaps in expectation and service provision which led to role conflict. There were also ambiguities in the client work to be done in the new role, which then highlighted ambiguities in the existing role. For instance, it was not easy to differentiate between counsellors and psychologists. Results were limited by the lack of generalisability because the sites that were audited, were selected opportunistically and the issues that were raised could not be useful in other areas. Also, the participants of the study reported on their expectations rather than on their experience.

A review of the available literature showed that role ambiguity, role overload and role conflict affect a growing number of community mental health nurses' performance and the quality of interventions. These role stressors also affect job satisfaction and the health and well-being of the mental health workers. Excessive workload and the lack of available resources were two main issues causing these role stressors which ultimately affect the performance of mental health workers (Edwards *et al*, 2000; Onyett, 2011). Absenteeism, high job turnover and low morale were reported as prevalent by the participants.

In a quantitative study of 41 NHS staff, MacAteer *et al* (2016) highlighted the tension and the conflicts that were experienced in mental health settings. They reported a negative correlation between role-efficacy and

organisational climate and the level of role ambiguity and role conflict (MacAteer *et al*, 2016). The study concluded that stress was inherent in the role of the mental health workers. Results were limited by the absence of qualitative data. Some would argue that a study relating to role ambiguity, role overload and role conflict should have a qualitative underpinning. This would provide deeper insights into the role of governance officers by giving thick descriptions about the participants' perceptions, opinions and experiences.

Sutton *et al* (2016) studied a schizophrenia outpatients' clinic and showed that the doctors, pharmacists and nurses that worked there, experienced role ambiguity. All the participants for this study reported a lack of understanding of their responsibilities and a need for clarification of roles. They also had different views about the value of the pharmacists in clinics. The results of the study indicated a lack of direction, an acknowledgement of unaddressed issues and role ambiguity.

New advanced roles for nurses

Efficiency-improvement strategies and their positive impact on patient outcomes within the NHS led to the development of some advanced specialist roles. These specialist roles were also developed because they retain nurses who do not want to pursue management roles in the profession. Eleven articles relating to advanced roles for nurses working in the NHS were retrieved. These roles included clinical research nurses,

community matrons, lecturer practitioners, nurse consultants, nurse specialists and advanced nurse practitioners (Seymour *et al*, 2002; Cooper, 2003; Leigh *et al*, 2005; Willard and Luker, 2007; Aranda and Jones, 2008; Spilsbury *et al*, 2008; Davies *et al*, 2011; Franks and Howarth, 2012; Peters *et al*, 2012).

Some would argue that the move toward specialist roles for nurses, midwives and allied health professionals (AHPs) over the last couple of decades was to plug the gap in reduction of junior doctors' hours. These specialist roles have more responsibility and they, therefore, are more accountable than roles of the 'ordinary' practitioner. Some of the specialist roles have, however, led to increased role overload and ambiguity (Willard and Luker, 2007; Peters *et al,* 2012). It is not clear whether with the newly-added tasks and responsibilities, other tasks were removed from the role. Notwithstanding, there were concerns that the role of clinical nurse specialists was ambiguous because they carried out dual roles (Brennan and Hutt, 2001; Williams *et al*, 2001; Jack *et al,* 2004; Manning *et al*, 2008; Scott and Timmons, 2017).

Stanley and Borthwick (2013) carried out a study on a sample of dietitians whose roles were extended to include home-based enteral tube feeding. The findings showed that there was an initial lack of role clarity with the tube feeding due to the expansion of their role boundaries. This caused some role overlap with the nutrition nurse specialists. However,

there was little dispute about it. This suggests that role ambiguity does not always cause problems.

A nurse consultant role was developed to support managers with commissioning, planning and policy implementation (Franks and Howarth, 2012). Nurse consultants have a wide remit spanning four areas: clinical consultancy, education, leadership and research development. Their role is still developing and issues such as role ambiguity, role overload and challenging relationships arise (Franks and Howarth, 2012). In their study on nurse consultants, Frank and Howarth (2012) reported that apart from the nurse consultant role being ambiguous, according to one participant, it lacks status and a strong voice. The participants felt that the role title was ambiguous and that there was a lack of understanding and support for the role. In addition, the nurse consultants were not always valued by managers and sometimes, the managers gave the nurse consultants some resistance.

Other miscellaneous roles

Art therapists working in learning disability services

One article was retrieved for roles in learning disability services where role ambiguity, role overload and role conflict are experienced (Ashby, 2020). Community-based art therapists and those working with inpatient services levels reported high stress levels during some change processes in the NHS, as they had to do more with fewer resources. This led to role

overload, with some participants reporting that they sometimes had to work overtime, including during their annual leave or weekends. Some art therapists felt that the NHS did not take art seriously. The increase in workload and the absence of suitable work conditions, e.g., inadequate office spaces, left staff weary and disillusioned. This was accompanied by burnout symptoms of emotional exhaustion which affected the health and well-being of some art therapists. Despite the above, the participants reported that they felt supported by the managers and team members.

Change agents

In a case study on middle managers who were acting as change agents, Tucker *et al* (2015) highlighted the importance of adequate role-sending and sense-making in the creation of new roles by change agents. The study involved conducting 82 interviews, and was supplemented by document analysis and field notes over three years. In role theory parlance, role-sending is described as the role expectations that are sent out to an individual by the role-set. Sense-making is the giving of one's personal meaning to the actions of individuals with regards change, while change agents or champions are the facilitators of the change process.

In order to reduce role ambiguity, adequate role-sending is important among change agents within NHS Trusts. Findings were that in the absence of a role-sender, the change agents drew upon the perceived expectations of other staff and their own ideas and experiences to make sense of a new role. In this case, there was some uncertainty with regards

the new role and also the role of the change agent. The article reported that the role of change agents with clinical backgrounds was ambiguous and complex.

Other roles

Nurse participants reported role conflict in three articles (Williams *et al,* 2001; Atwal, 2002; Cooper, 2003). Radiographer managers also had dual roles and they experienced role ambiguity; however, they were able to cope (Forbes and Prime, 2000). Maternity care assistants were reported, in one article, as also coping with role ambiguity – these roles did not experience any conflict (Willocks, 2011). Role ambiguity and role overload were reported in occupational health physiotherapists' and intensive care nurses' roles (Atwal, 2002; Davies *et al*, 2011). Leigh *et al* (2005) highlighted the benefits of having roles such as lecturer practitioner: the quality of teaching is enhanced, while expertise is maintained. Role ambiguity was due to the lack of clarity between the lecturer practitioners' responsibilities to both practice and education.

The literature shows that role ambiguity, role overload and role conflict are not unique to governance officers. Other groups within the NHS experience these role stressors, albeit, in various degrees. This could be because the NHS has to develop new roles to meet increasing and varying demands. There is crisis in the recruitment and retention of traditional

roles, such as nurses, midwives and GPs, requiring the development of less costly support roles.

Part Two

2.3 Conceptual and theoretical frameworks

2.3.1 Introduction

The review of the available literature showed limited discussions, conceptual weakness and a lack of theorisation. Hence, it was felt that the thesis should draw on deeper conceptual and theoretical frameworks to underpin the study on how governance officers ensure accountability in an NHS Trust.

2.3.2 Concepts

Concepts are complex mental formulations of experiences, i.e., the totality of what is being perceived – the feelings, values, attitudes, etc. They occur along a continuum from the empirical, formed from encounters with the world, to the abstract, mental images of an experience (Chinn and Kramer, 2015). The concepts that will be discussed first are 'clinical governance' and 'accountability'.

2.3.2.1 Clinical governance

There has been a lot of interest around clinical governance. Although it was introduced in the United Kingdom, it has been embraced by healthcare organisations in other countries such as USA, Australia, Canada, China, Denmark, Italy, Nepal, New Zealand and Iran (Degeling *et al*, 2006; Baker *et al*, 2010; Donaldson and Darzi, 2012; Dehghan *et*

al, 2013; Kaini, 2013; Berg and Black, 2014; Mainz *et al*, 2015; Sarchielli *et al*, 2016; Legat and Balding, 2019). A plethora of literature exists on clinical governance (Scally and Donaldson, 1998; Nicholls *et al,* 2000; Onion, 2000; Halligan and Donaldson, 2001; Flynn, 2002; Freedman, 2002; Baker, 2003; Freeman and Walshe, 2004; Som, 2009a; Som, 2009b), but not explicitly on the governance officer role.

There are many definitions and dimensions of the term, 'clinical governance' and this, perhaps, explains its lack of clarity. The dimensions of clinical governance that are pertinent to this thesis are those that are related to accountability. Clinical governance was defined in Chapter 1 as a framework by which NHS organisations are accountable for safeguarding high-quality care.

This definition shows the strong link between clinical governance, accountability and quality. It signifies the importance of ensuring accountability in the drive for good governance. It also highlights that in order for high-quality treatment and care to be provided, there has to be the right environment for excellent clinical performance.

Sealey (1999) explains that clinical governance is a framework for improving the quality of patient treatment and care. This is carried out through audit, incident and risk management, shared learning, health and safety and losses and compensation, etc. Patient safety is placed at the forefront through the efficient use of groups of people. This adds to

the importance of teams in ensuring good governance. For teams to be efficient, there should be appropriate roles in place that are in line with the goals of the organisation (Mullins, 2013). This portrays governance as a bridge through which all stakeholders collectively deliver high standards of patient care (Crinson, 1999; Donaldson, 2001; Freedman, 2002). Figure 4 illustrates the different components of clinical governance that aim to ensure good-quality care and treatment – clinical audit, risk and incident management, education and training and resource effectiveness (Gibson and Ward, 2000; Swage, 2004; Som, 2009a; Gottwald and Lansdown, 2014).

For good governance to be embedded, there should be robust education and training so that staff understand their responsibilities. In addition, the organisation should identify, assess and minimise risks and also measure performance. Clinical governance involves researching in order to identify best practice, investigating problems and learning from them, and being open and transparent (DH, 1998). Heath (2005) states that the above components of clinical governance had always been in place. With the introduction of formal clinical governance, there was a greater focus on bringing the components together under one umbrella. In addition, clinical governance aimed to usher in a culture change, i.e., a 'no blame' culture, accountability for the quality of treatment and care to lie with a Trust, and legal responsibility for high quality of care to rest with the chief executives (Tilley and Watson, 2008).

Figure 4: Components of clinical governance

The principles of clinical governance apply to all staff that provide and manage patient care and treatment (Wilson, 2004; Lugon, 2006). To achieve effective clinical governance, there should be a positive culture, a common set of values, good teamwork and communication and also good leadership (Freeman and Walshe, 2004).

The focus of clinical governance could be viewed from three levels: micro, macro and meta levels. Clinical governance at the micro level is done locally, i.e., within the directorates. This study focuses on the micro level. The two other levels, macro and meta, relate to clinical governance at the Trust and national levels. Governance at the macro level is the combination of governance activity in all the directorates, while governance at the meta level relates to collective activity within the UK.

2.3.2.2 Accountability

In order to address the research questions effectively, it is pertinent to understand what is meant by accountability. Providing a standard definition of the term is difficult. It is an abstract, complex and fluid concept that can be interpreted in a variety of ways (Day and Klein, 1987; Ryan and Walsh, 2004; Dixon *et al*, 2010; Maybin *et al*, 2011).

Some of the common features of accountability are that it involves answerability, i.e., the expectation to report and explain one's actions. Also, it implies rights of authority, as the group calling for accountability is asserting rights of superiority over those that are accountable. Dewar (2000) advises that with regards accountability, there are two dimensions to power: explicit power and implicit power. Explicit power could positively or negatively influence an individual's career and remuneration, while implicit power is the ability to use a person's profession, personality or status to influence explicit power.

One of the dimensions of accountability that is of relevance to this study is in the context of people being held to account against clearly specified criteria (Day and Klein, 1987; Ryan and Walsh, 2004). In the NHS, employees have set responsibilities and they are potentially accountable to multiple people. Accountability in the NHS weighs heavily on the internal governance system which is supported by scrutiny committees (Maybin *et al*, 2011). It also depends on the

perceptions, values and behaviours of the stakeholders, including the power of each of them (Mulgan, 2000; Bassett, 2012).

Lines of accountability can be approached from the strategic, corporate and local levels (Maybin *et al,* 2011). The NHS has clear lines of accountability at all levels for the overall quality of care and responsibility (Field, 1999). Accountability can also be viewed in terms of:

- Personal accountability
- Administrative accountability; efficiency and correctness
- Professional accountability; ethical standards, professionalism
- Social accountability; officials are made accountable by society
- Horizontal accountability exercised between groups (Bovens, 2007).

Another approach to describing accountability was suggested by Watson (2005):

1. Individual accountability
2. Professional accountability
3. Corporate accountability.

Individual accountability

Where individual accountability is required, the specific staff assume the role of the account-giver (Rock, 2020). The performance of this individual is assessed against the role expectations. All healthcare staff are

individually accountable, irrespective of whether they are supervised. They are expected to provide justifications for their actions (Tilley and Watson, 2008). Their responsibility cannot be delegated. Registered nurses can, for example, delegate to care assistants, but registered nurses remain accountable.

Persons who are individually accountable need to acquire the appropriate skills, strive to maintain high standards of work, abide by policies and procedures and carry out tasks to the best of their ability, while being aware of their limitations. With individual accountability, information should be accurate, up-to-date and readily available, while deviations should be justified and documented. High-quality performance could possibly be impacted by a high level of individual accountability. The system, structures, available support, resources and culture also promote certain behaviours which could possibly influence individual accountability (Aveling, 2016).

Professional accountability

Where members of staff belong to a professional or regulatory body, they are accountable to those bodies for their conduct. The priority of the professional bodies is to ensure the well-being of those registered with them, while regulatory bodies ensure that set standards are met. Nurses and doctors are accountable towards the Nursing and Midwifery Council (NMC) and General Medical Council (GMC), respectively. They act based on their professional judgement, and may be called upon to justify those

actions (Jordanoska, 2021). In addition, they are responsible to their peers within their Community of Practice. Staff are also responsible for their continuous professional development and learning. They are required to show evidence for revalidation and they have a lifelong duty of care (DH, 1998). Being professionally accountable makes staff self-aware and enables them to improve performance.

Corporate accountability

The NHS Trust is corporately accountable for the delivery of high-quality treatment and care to patients. With the current financial predicament of the NHS, it is essential that the organisation provides services to the public that are efficient, effective, sustainable and that demonstrate value for money. Ultimate responsibility for high-quality care lies with the chief executive. Apart from the public and Commissioners, the Trust is also accountable to other stakeholders, such as, CQC, NICE, NHS England, Monitor, the Parliament, etc. This is made possible by having efficient systems of communication, risk management and performance management (McSherry and Pearce, 2007; Tilley and Watson, 2008).

The different types of accountability sometimes conflict with one another. For instance, individual accountability, professional and administrative accountability tend to clash. Some clinicians view their individual and professional accountability as being paramount (Bassett, 2012). Other types of accountability such as administrative accountability, which involves monitoring processes, are considered to be less important.

As highlighted by Field (1999), for accountability to be in place, there should be:

- simple transparent processes
- clear roles and responsibilities
- support for learning and improvement
- constant monitoring against objectives and timescales.

Governance officers support directorates so that they are accountable for their performance and so that they can provide justification for their actions. It could be argued that governance officers enable an environment for support which is facilitated by the above mechanisms for strong accountability. The accountability of staff for the whole organisation's performance is also argued to be important in improving clinical performance (Donaldson, 2001).

Accountability takes into cognisance any consequences that might arise as a result of failure to abide by the rules and regulations of the organisation. However, Bassett (2012) advises that staff should be accountable only for the actions and decisions that are in their power to make and for which they have been given responsibility.

2.3.3 Theories

Theories are well-thought guiding principles that explain and help in understanding phenomena. They are the lens through which the researcher views the world. Different theories use different lenses to

explain phenomena. Chinn and Kramer (2015) describe a theory as a set of hypotheses or systems of frameworks that are conceived to serve a purpose. Their theoretical frameworks act as the bases for conducting a study and they also determine the areas that will be examined.

The role of the clinical governance officer involves ensuring that clinicians are accountable at the local level of the NHS. Their role pivots between two powerful staff groups – consultants and senior managers – as a result, their experiences are structured by power relationships. The interactions of the governance officers within a team too enable them to develop a sense of shared experience.

To achieve the aims of this study, it is necessary to examine perceptions of governance officers on their role using appropriate theoretical frameworks. Having reviewed the literature, three theoretical approaches seem especially relevant here. Developed in the early 1930s, role theory is a collection of concepts and perceptions that relate to how individuals act out roles. Each role specifies a certain number of behaviours and duties. Role theory emphasises the interactional aspects of being part of a group. As role theory is a study of roles, it provides a theoretical framework for this study which explores the role of governance officers. Role theory will enable an understanding of the behaviours, expectations and duties of governance officers. It will also enable an exploration of how governance officers view their role of ensuring accountability at the local level.

Foucault's theory of power analyses how power is used for the regulation, surveillance and control of people. This theory has been widely identified as crucial in bringing about enhanced understandings of power. Foucault's theory of power was chosen over the other theories of power because it takes into consideration, discourse and knowledge alongside power (Foucault, 1977; Foucault, 1978; Gordon, 1980; Dreyfus and Rabinow, 1982; Hugman, 1991; Raffinsoe *et al*, 2019).

Bourdieu's theory of habitus which introduces concepts such as capital, habitus and field will be reviewed. These concepts help to further explain the role of governance officers and their ability to ensure accountability.

2.3.3.1 Role theory

Biddle (2013) defines role theory as:

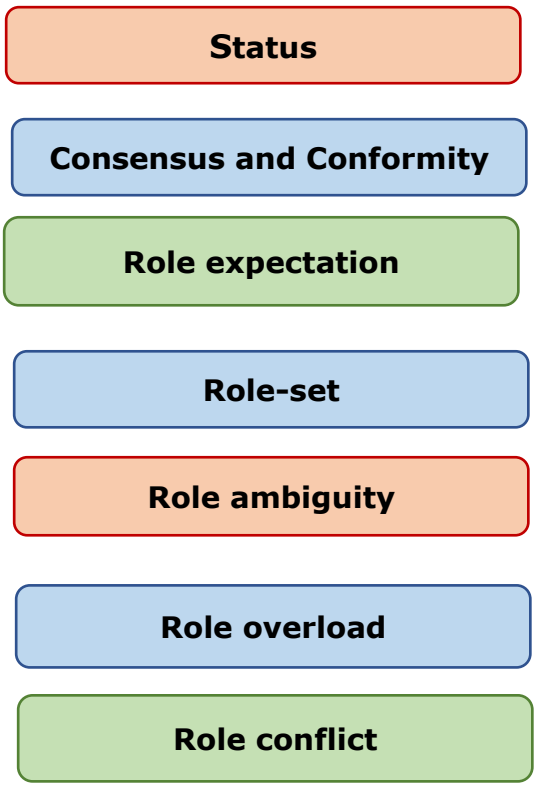
> *…concerning itself with a triad of concepts: patterned and characteristic social behaviours, parts or identities that are assumed by social participants and scripts or expectations for behaviour that are understood by all and adhered to by performers* (Biddle 1986, p. 68).

Notwithstanding its long history, the name 'role theory' and the use of ambiguous terminology within role theory still causes some confusion. This 'theory' is more of a 'diverse, multidisciplinary field of research that addresses human interaction' (Guirguis *et al*, 2005). Also, the variety of definitions relating to the word, role – 'role incumbent', 'focal person', 'role-taker' or 'role-bearer' (Allen and Van de Vliert, 2012) make role theory ambiguous and cumbersome to explain.

According to Biddle (2013), the variety of the definitions causes confusion, as it becomes unclear which of the definitions to adhere to and how to address events that do not meet these conditions. A common theme with the definition of the word, 'role', relates to behaviour, i.e., behaviour towards different phenomena; behaviour towards patterned expectations (Linton, 1936); comprehensive pattern for behaviour and attitude (Bates and Harvey, 1986); behaviour referring to normative expectations associated with a position in a social system (Allen and van de Vliert, 2012); the expected set of behaviours associated with a specific position or status (Biddle, 2013). There is some confusion and uncertainty as to whether role behaviours are associated with a function, a position or behaviours and attitudes.

A role is the behavioural expectation that has been assigned to an individual. This would include descriptions of the characteristics, behaviours, norms and values (Biddle, 2013). A person performs a role when he puts the expected rights and duties into action. Figure 5 shows the seven concepts of role theory that are of key importance with my study on governance officers. These have been studied widely (Rizzo *et al*, 1970; Katz and Kahn, 1978; Biddle, 2013).

Figure 5: Key concepts in role theory



Status

A status can be described as a specific position in a social system involving designated rights and duties (Biddle, 2013). 'Roles' will be discussed from the point of view of status. A set of persons sharing the same status will, most probably, exhibit a similar identity. Governance officers refer to a specific set of persons who occupy a social position and who are expected to behave in a characteristic manner. The definitions of role and status resonate with the role of the governance officers in the study. The role of a governance officer is made up of tasks such as administrator, adviser, auditor, analyst, data input officer, educator, etc. All governance officers are expected to conform with these tasks because

they share the same role expectations.

Consensus and conformity

Consensus is the shared sense of expectations, beliefs and values of a group of people (Biddle, 2013). In this study, consensus within the governance officer team is of special interest. Teams are generally described as comprising a group of people bound by consensus and working together to achieve common agreed objectives. Theorists argue that systems are better run when there is a shared belief on conduct. Having consensus around norms enables organisations to be integrated and operate smoothly. Consensus with the roles is not always total, as some individuals could reject or remain neutral to aspects of their culture. Conflicts could arise within groups, and where norms are not followed there are, sometimes, consequences (Biddle, 2013; Mullins, 2013).

In addition to consensus, there should be role conformity. Conformity involves complying with some pattern of belief or behaviour within a group (Biddle, 2013). It is brought about by a positive relationship between expectation and behaviour. Persons within a social structure have a corresponding social role and a set of expectations and behaviours (Linton, 1936). The role of the governance officer comprises an expected shared set of activities, cultural norms and behavioural patterns. These are taught roles that they are expected to conform to. Biddle (2013) states that individuals are more likely to conform when others can view

their work, have power and can impose sanctions over them. Other theorists argue that people's preferences could affect their conduct. Where non-conformity exists, it could sometimes be seen as positive, because it generates evolution by introducing new ideas and behaviours for a changing environment as the NHS (Biddle, 2013).

Role expectations

Role expectations are the scripts for behaviour and they denote what a person ought to do or ought not to do, under certain circumstances, e.g., job descriptions, standard operating procedures, etc. (Merton, 1968; Kahn, 1978; Biddle, 2013). Roles of formal organisations are associated with identified positions and they are created from normative expectations, which are laid down at the onset of employment.

These expectations should be clearly communicated to staff via effective training. Staff role expectations have to match the objectives of the organisation to make the encounter meaningful. Where there is an absence or inadequate level of training and communication, staff are likely to experience anger, anxiety, demotivation and frustration. It has been shown that this also has the tendency of lowering self-esteem (Buchanan and Huczynski, 2017).

Other factors that influence role expectations are personal characteristics and capabilities. Although the roles within the team are responsible for the team's success (Belbin, 2013b), the success of the team also depends

on the suitability of the role occupant based on their personal characteristics. Belbin highlighted three categories of roles which contribute to the success of a team: action roles (completer-finisher, implementer and shaper); social roles (co-ordinator, resource investigator and team worker) and thinking roles (monitor-evaluator, plant and specialist). Belbin's theory conflicts with role theory as he argues that team roles are based on individual preferences centred on personality and not on the expectation of others. This is true to some extent, as individuals in a team tend to settle for certain preferences. Once the managers identify this, they can compose a successful team which is made up of the required role preferences. Motivation and environmental resources such as, equipment, finance and technology also influence role expectations.

Role-sets

The entire group of persons with whom relationships are held is known as the role-set (Merton, 1968). This includes all the roles that are attached to a single status. The role-set for the governance officers would comprise other governance officers within the team, healthcare governance managers, support team leaders, audit convenors, clinical directors, matrons, directorate managers and other clinicians. This will also include the commissioners, Department of Health, NICE, CQC, etc. The scope of the role-set is indicative of the complexity of relationships that the governance officers have.

Merton (1968), in his classic discussion, suggested that some of the factors that influence the operations of role-sets include:

- the relative importance of the different statuses
- differences in power of the members of the role-set
- concealing of activities from other members of the role-set
- observation of conflicting demands by members of the role-set
- mutual social support amongst status

Governance officers, consultants and senior managers are on different levels of importance and power, with governance officers at a lower level. This could negatively impact on the operation of the role-set.

Role ambiguity

Role ambiguity refers to conditions where workplace procedures are unclear and uncertain, and the individual does not have a clear direction about the expectation of their role (Katz and Kahn, 1978; Biddle, 2013). This takes place when tasks are not clearly defined. Two workplace principles: the chain of command and the unity of command are important in alleviating role ambiguity. The former principle states that hierarchical relationships with a single flow of authority from the top to the bottom are more effective and give more clarity, while the latter states that individuals should have a single superior and a single plan.

The complex role-set that surrounds the governance officer could possibly allow for multiple orders, thereby enhancing role ambiguity. This usually

occurs when an individual is new to a role or when there are changes to a process or structure. Role ambiguity can be avoided by having clearly-defined roles with aims and objectives. It has a negative impact on performance (Moustaka and Constantinidis, 2010) and it impacts negatively on a team's success and on an individual's well-being. It possibly limits understanding and confidence and leads to role strain and role stress. The ability to manage role stress sometimes depends on an individual's personality. Together with role overload and role conflict, role ambiguity could cause anxiety, low job satisfaction, tension, lower productivity and work-related ailments, such as burnout (Rizzo *et al*, 1970; Katz and Kahn, 1978; Glazer and Beehr, 2005). Role overload and role conflict are discussed in the sections below.

Role overload

Role overload occurs when a person has too many expectations (Biddle, 2013). This is caused when diverse expectations occur simultaneously with the potential of interfering with the status structure, performance of the status occupant and hinder effectiveness and efficiency (Merton, 1968). Role overload could also be due to the lack of skill and education to carry out a task. Sometimes, role overload occurs when there is conflict between several roles that are undertaken by one person (Rizzo *et al,* 1970). In such cases, the demand is excessive and this impacts negatively on the role – causing role pressure. Role ambiguity and role overload could possibly cause role strain, i.e., the felt difficulty of fulfilling

role obligations (Goode, 1960; Rizzo *et al,* 1970).

Role conflict

Role conflict has been defined as the simultaneous appearance of two or more incompatible expectations for the behaviour of one person. The issue of role conflicts is important; if not properly addressed, it could lead to negative emotions such as role pressure, role stress and also frustration (Rizzo *et al*, 1970; Katz and Kahn, 1978; Schmidt, 2000; Biddle, 2013).

Roles are dynamic and a change in a situation could impact on the role. For instance, an employee leaving the team could affect the role of other team members and this might affect their ability to meet expectations, leading to role conflicts. Pressure could also possibly be experienced where there are multiple sources of the norms. Role conflicts could enhance job satisfaction and employee productivity – this has a negative impact on the goals of the group.

Other assumptions underpinning the role theory highlight that role conflicts tend to occur when multiple roles compete for space, time and values. This could occur when there is too much work and the employee is unable to meet the demands of the role. The way in which role players relate to each of the role senders varies, as expectations of conduct are different and are, sometimes, conflicting. One cause of conflict in expectation is due to the different social positions that members of a role-

set occupy. For instance, governance officers and consultants, have different interests, values and expectations, which lead to the potential for conflicts. Ways of reducing role conflict include conforming to expectations; compromising and avoiding the issue; altering expectations; modifying behaviours to be in line with the role expectation and delegating some of the responsibilities (Katz and Kahn, 1978).

Role conflict affects the performance of staff and ultimately impacts on the smooth-running of the organisation. Role conflicts could, however, sometimes be positive. They could possibly bring about improvements and innovations, due to the in-depth discussions about the issues at hand, thereby reducing ambiguity.

Role theory is diverse and complex with several approaches – cognitive behavioural role theory, structural role theory (Linton, 1936), functional role theory (Linton, 1936; Merton, 1968), symbolic interactionist role theory (Mead *et al*, 2015) and organisational role theory (Katz and Kahn, 1978). The approaches of role theory that resonate with this research study are the structural, functional, organisational and the symbolic interactionist approaches. Of these, the functional and interactionist perspectives seem relevant to this study and they are discussed below.

Functional role theory

Functional role theory focuses on the behaviour of persons who occupy stable social positions within a system (Guirguis and Chewning, 2005). Roles are the shared expectations about a function. Individuals are socialised into roles and their behaviours are patterned and can be predicted. In addition, behaviours are dynamic, and they allow variability among different persons in the same role (Allen and van de Vliert, 2012). Roles are usually 'hierarchical, pre-planned and task-oriented' (Biddle, 2013). For instance, in NHS Trusts, an organisational structure exists and each role has a job description. The roles are, however, not always stable.

Merton (1968) asserts that where individuals are socialised fully into a culture, the culturally-approved ends and means towards the achievement of their goals will be acceptable to them. However, where there is a rift between the culturally-accepted ends and means, there will be issues around conformity – Merton's concept of anomie (Fulcher and Scott, 2007).

Functional role theory has significant limitations. Functionalist theorists tend to understate both the potential for conflict and the way that social and organisational roles are moulded by unequal power. Some roles are not associated with functions and also, roles are not always constant (Biddle, 2013). In addition, norms are not always shared, and they are not always adhered to – non-conformity does not always lead to sanctions. The functional role theory does not consider deviant

behaviours, neither does it consider the importance of structures that are in place.

Symbolic interactionist role theory

This theory looks at the roles of individuals, through their communication and social interaction with others via symbols – gestures, words, etc. Roles are constantly reshaped and as a result, the social interactions that occur with 'significant others' and 'generalised others' (society), are not permanent (Mead *et al*, 2015).

The interactionists argue that people give meaning to the world around them from the experiences derived from social interactions. This influences how individuals see reality. Interactions form the bulk of the governance officers' work life. The types of interactions that occur between governance officers and others are determined by the roles they have. Because social interactions are subject to change, people's meaning of symbols change with time. This has an effect on how people see reality and how it influences our actions. Interactionists believe that roles are also shaped by the culture and values of the institution.

The fluid nature of the role is acknowledged by symbolic interactionists who emphasise relationships among roles. Individuals negotiate their roles as they develop, and there is a tendency to behave according to the expectations of society. Where a satisfactory negotiation has occurred, there will be role-fulfilment. If otherwise, there could be role ambiguity,

role conflict or role overload, depending on the situation. These role stressors affect work performance and job satisfaction. They could also cause mistakes, frustration, confusion and misconduct (Schmidt, 2000). Low personal capability and limited resources can negatively impact on an individual's role.

Identity and self

The concept of identity relates to social groups to which an individual belongs. Identity has been described as the sense of self that an individual has. Although this term could sometimes be confusing, it is imperative to discuss identity because it relates to role theory. It would also help to answer a research question for this study.

Mead *et al* (2015) explain that people develop self-images based on the interactions that they have had with others. The identity or sense of self is based upon the management and outcome of social encounters. Identity is fluid and Mead *et al* further describe it as emerging from external social interactions and internal feelings. They argue that self-image and self-awareness are products of social experience. Biddle (2013) also states that people behave in different ways based on their identities and the situation.

There is a debate to be had about whether identity is who we think we are, who we think others think we are or who others think we are. Verkuyten describes a sense of identity as an awareness of the value,

recognition and respect of an individual (Verkuyten, 1986). The actual meaning of identification lies in the derived self-esteem; identity and self-esteem are closely-related. Negative evaluation of a person's identity could be painful, whereas positive evaluations denote a sense of worth. McCall and Simmons (1978) argue that roles are developed as individuals seek to fulfil their goals. They explain that role identity is devised by the individuals who occupy a particular social position.

Social identities highlight a person's position in a social structure. An individual's role identity is how they see themselves in a particular position, and legitimising their position in the opinion of others is a major goal. People also evaluate themselves based on their role performances as they occupy these positions. However, they still need the support of other external parties in order to confirm their role identities. This support extends to receiving approval for the dressing, behaviour, mannerisms, style, emotions, etc. that legitimise the role.

There is usually some discrepancy between the role identity conceived in a person's mind and the role support that is provided by the external audience. Some people tend to over-idealise their role identities; likewise, role support from the audience could be misinterpreted. There is, therefore, the potential for dissatisfaction based on how much of an individual's identity has been legitimised. Optimally, there should be a balance between role identity and the support received from the external audience. Notwithstanding, the points of disjuncture between role

identity and role support motivate and drive a person's behaviour. McCall and Simmons (1978) assert that the main emotion of individuals is the desire to gain support for their idealised conceptions of themselves. For example, governance officers need the co-operation and support of the staff that they interact with at a local level. Learning and socialization are important in developing the self (Bilton *et al*, 2002).

The self relates to an individual's physical characteristics, behaviour, beliefs and self-esteem. It is closely related to social identity which is the public self (Allen and van de Vliert, 2012). A person's conception of self and identity is based on their social roles. The total self is the sum total of all the roles that the person performs (Goffman, 1969; Allen and van de Vliert, 2012). In addition, skill level, education and general attitude, e.g., to tension, could impact on the job role. The identity of an individual is linked to the structures and processes within the society. Individuals within the society are seen as having an agreed set of values, beliefs, principles and ideas.

Dramaturgical theory of self

The dramaturgical theory of self is about the activities and behavioural patterns in social life, which can be compared to acting in the theatre.

In his 1956 book, *The Presentation of Self in Everyday Life*, Erving Goffman (1969) put forward the theory of social action in which he used a theatrical metaphor to attach meaning to human actions. This was also

inspired by Mead *et al*'s (2015) theory of social interaction. According to Goffman, everyone is an 'actor' and those who occupy these positions are expected to behave in specific ways which define their 'roles.' Goffman's perspectives are that people live a life of drama as they manage their behaviour, clothing, settings, words, etc., in order to portray a particular impression of themselves – impression management or presentation of self (Goffman, 1969).

Goffman (1969) argued that there is no real self. People 'act' on the stage of life because they believe that this can be interpreted as saying something about them. Hence, they attempt to manipulate others' interpretation of themselves and improve their self-image. Impression management emphasises the diversity in social roles. People are constrained to perform based on the 'scripts' that they are given. They think of themselves in the way their image is reflected by those who are the 'audience'. Likewise, how people view their environment and social world is influenced by their perception of self. This self is sometimes alternatively conceived as our identity or a series of identities which we portray to an audience. Once this self is revealed, the onus is up to the audience to place an identity on the individual.

Goffman (1969) states that there are special scripts associated with some of these roles. The individual needs to understand the role in order to communicate and act it out effectively. Intrinsic to this, is the role that culture plays and the 'generalised others' who limit an individual's

creativity and subdue their potential. The perspectives have been criticised as labelling the 'actors' as con artists who manipulate their behaviours to maximise gains (Allen and Van de Vliert, 2012).

Limitations of role theory

Jackson (1998) highlighted some limitations of role theory. Firstly, she argues that role theory categorises roles into concrete entities and it renders a false sense of universality. According to Jackson (1998), role theory does not consider deviations from normal behaviour. It objectifies behaviour – which gives a wrong assumption, because there are many aspects influencing an individual's makeup: age, culture, background, gender, etc. Role theory compartmentalises roles, which is not the case in reality – occupations are not segmented. Quite a number of occupations are enfolded; they are multi-faceted and involve some amount of multi-tasking.

Secondly, role theory places emphasis on conformity and consensus at the expense of social policies. Individuals are expected to conform to certain social performances which lead to a consensus within the group. The flaw of argument here is that issues relating to deviance, or role conflict are viewed from an individual level and not in relation to other factors such as inequalities based on age, race, class or power relations.

Thirdly, contrary to what role theory states, the socialisation process within individuals is not always as a result of modelling other peoples'

behaviours. Power relations could possibly play a part in defining an individual's actions. Fourthly, as a result of the objective perspective to which roles are attributed, there is not much room for agency. Meanwhile, irrespective of consistency with the norm, agency potentially plays a part in dictating an individual's actions based on their emotions and the meanings that they give to their actions. Resistance to social norms is also argued as being downplayed. An individual's creativity and their ability to make choices against the backdrop of social and economic forces are disregarded by role theory.

Lastly, Biddle (2013) highlights the confusion around the many meanings of the concepts and terms, which characterise role theory with ambiguity. There is ambiguity over the definitions of terms and explanations of the phenomena relating to roles. For instance, some would refer to the term 'role' as the characteristic behaviours of an individual, a set of norms, while others would refer to it as parts to be played (Biddle, 2013).

The above limitations highlight role theory's inadequacy to provide a suitable framework with which to explain the complex interactions of individuals, and by extension, of governance officers. Hence, Foucault's theory of power and Bourdieu's theory of habitus have been introduced to support it.

2.3.3.2 Theory of Power: Michel Foucault

We have seen that accountability is influenced by power. Understanding power issues is an important part of understanding the governance officers' role. For accountability to be appropriately explained, it should be discussed in the context of power and control. Theories of power are appropriate for unravelling the inherent power relationships around governance officers. Role theorists do not ignore power which can also be described as the capacity to impose an individual's or a group's will on others, i.e., if the individual or group enjoys a monopoly of power (Merton, 1968; Weber, 1978). Power is, however, not at the centre of their analysis.

From the late 1960s, a new group of theorists tried to focus on the nature of power and its importance in social relations of all kinds. Not the least was the French writer, Michel Foucault. Foucault defines power as the:

> *multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organisation; as the process which, through ceaseless struggles and confrontations, transforms, strengthens, or reverses them: as the support which these force relations find in one another, thus forming a chain or a system, or on the contrary, the disjunctions and contradictions which isolate them from one another* (Foucault, 1978, pp. 92 – 93).

I am interested in this more complex and contextualised reasoning, because this thesis is concerned with relationships that are found within structures. Power is not only described in the context of resistance, but also as a dynamic and systematic entity.

Foucault explains how, throughout history, there has been power and control over the general populace of society. He particularly focuses on surveillance as a form by which power operates and he uses the example of the Panopticon, as a model of surveillance. This explains power relations in which there exists, enhanced and continuous visibility of the objects of power (Dreyfus and Rabinow, 1982; Raffinsoe *et al*, 2019). This is a form of power that is based on power dynamics, where people act in a disciplined manner in case they were being watched. Foucault describes how gradually, in prisons, schools and hospitals, the state did not need to coerce individuals, as they learned to control themselves because they could differentiate between normal and deviant behaviours (Foucault, 1977). Surveillance was and is still used to steer individuals by placing them under the authority of someone responsible for what they do (Raffinsoe *et al,* 2019).

Since the whole system of governance in the NHS is explicitly linked to surveillance, Foucault's focus on power and surveillance seems especially relevant to the arguments about accountability in the NHS. Surveillance is manifested in most of the activities that governance officers are involved in. Managers use various forms of power and surveillance as sources of discipline and conformity, i.e., visible decision-making mechanisms and activity-regulating powers. Surveillance also takes place via the regulation of performance by external agencies, scrutiny meetings, committees and the Trust Board.

Power within the context of healthcare organisations emanates at both the macro and micro levels. At the micro level, the dominant discourse is held by those with the most power – the powerful clinicians and senior managers. Foucault argues that power is linked to knowledge, scientific understanding and truth. This is evident in NHS Trusts where, due to knowledge and expertise, consultants wield a lot of power. This power places them in a class above other groups of staff (Hugman, 1991). Foucault believes that by extending power, it is possible to generate more knowledge, collect more information and exercise more control over the people (Gordon, 1980). He argues that discourse, the way we talk about issues, think about or depict them, frames the way they are identified. According to Foucault, discourse is used to avert or subvert the strategies of power and it changes over time. Foucault argues that power is not concentrated in one place; it is ubiquitous.

All social interactions are fundamentally relationships of power which spread throughout societies. Foucault believes that power is not possessed; it is exercised. Power can be positive and productive; enabling people to do things - but total control is never given (Haralambos and Holborn, 2013). Foucault argues that power, being an everyday phenomenon, cultivates discipline and conformity. Power determines the conduct of individuals via, policies and protocols. These are put in place through the power that is invested in senior managers. These, in addition

to functions of checking and control, form part of the power structures that influence the behaviour of clinicians.

Foucault believes that power is dispersed and within the NHS, power has been described as lying in the hands of the consultants and the senior managers. Some have described clinicians as having negative views about clinical governance and, therefore, not engaging with the governance officers (Wallace *et al*, 2001; Degeling *et al*, 2004). They might be averse to the seeming surveillance that is placed over their activities, e.g., to assess their compliance to Trust policy, etc. Also, systems of surveillance have been employed by managers to enforce discipline and maintain dominance. Surveillance could possibly bring about competition, empowerment and also enhance a sense of responsibility. Other members of staff have power because of their large numbers, the type and volume of information that they hold.

2.3.3.3 Theory of habitus: Pierre Bourdieu

The French sociologist, Pierre Bourdieu, too has had a great impact on social theory. His theory of habitus introduces concepts such as capital (cultural, economic, social and symbolic), habitus and field. Bourdieu describes habitus as:

> *'the system of durable, transposable dispositions, structured structures predisposed to function as structuring structures, i.e., as principles which generate and organise practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express*

> *mastery of the operations necessary in order to attain them'* (Bourdieu 1993, p. *5*).

Simply put, habitus is the set of internal characteristics that govern a person's behaviour. It reflects the way in which people view the world and the tastes, preferences and lifestyles that they have. Habitus is influenced by background, education, class, gender, ethnicity and past experiences (Bourdieu, 1993; Costa and Murphy, 2015). These are seen by some as reflecting distinction between social groups. According to Bourdieu, habitus plays a part in mapping out a person's identity; it is a framework for behaviour and when an individual (known as the agent) enters a field, they bring with them, their habitus (i.e., their resources; the amount and types of capital that they possess).

Bourdieu argues that people are socially categorised into classes based on the amount of capital they possess. He further argues that types of capital can be used to gain power, status or wealth (Bourdieu, 1993).

- Cultural capital is obtained from educational qualifications and professional credentials. It also includes knowledge and understanding obtained from artistic aspects of culture, such as arts, cinema and drama. Cultural capital is portrayed as social style, manners, linguistic ability, etc. Bourdieu describes cultural capital as the capabilities that enable an individual to distinguish themselves in society. The more cultural capital a person has, the more successful and powerful they

will be and *vice versa*. Governance officers have less cultural capital than consultants and managers and are, therefore, less powerful.

- Economic capital provides command over economic resources, such as money, assets, etc. This is not evenly distributed. For example, consultants earn more than managers and much more than governance officers.
- Social capital relates to the network of friends and contacts that a person has. Economic capital, income and wealth – in the form of money, land, property or shares also constitute social capital.
- Symbolic capital is how a person presents themselves in everyday life, i.e., the image of 'respectability and honourability'. Physical capital, physique, gait and mode of talking make up social capital.

Bourdieu argues that the amount and type of capital a person has influences their lifestyle, and classes are distinguished based on this. It is possible to exchange capital and, in so doing, move from one class to another. However, Bourdieu warns that the chances of the working class moving up economically and socially are limited. As the states of capital are fluid, Bourdieu believes that culture and lifestyle can influence a person's chances of moving up the classes. In other words, those with high cultural capital may use this to obtain more economic capital.

Fields are spaces of power, conflict and competition. On entering a field, the individual is evaluated and ascribed a position based on the total capital that they have (Bourdieu, 1993). Bourdieu describes a field as:

> *'a separate social universe having its own laws of functioning, its specific relations of force, its dominants and its dominated, and so forth'* (Bourdieu 1993, p. 163).

This social space has its own written and unwritten rules – also known as *DOXA*. To align this with the healthcare setting, the Trust is the field wherein groups tend to dominate themselves based on their acquisition of cultural capital. The most powerful are those with the most capital. Consultants carry the most capital and they have the ability to change the rules to suit themselves. Other staff occupy levels within the field based on the fit between their habitus and the field that they are in.

Bourdieu's work is also around power in society. In his study, he highlights the relationship of these concepts to power and he insists that through interpersonal relations, those in power can maintain their positions. The people with high cultural capital such as consultants and managers, can draw upon this capital to realise their goals.

Critics of Bourdieu have argued that his works disregard individual choice and the impact of agency (Haralambos *et al*, 2013). Bourdieu positions rules as more important in decision-making than agency. He has been criticised, not only for disregarding the individual's capacity to act freely, but also for not considering the dynamic nature of individuals.

Another area of criticism lies with Bourdieu's suggestion of the fixed reproduction of structure, i.e., that a particular habitus would result in a particular class or position. There is no consideration of deviations, i.e., subjectivity, to this – it is not 'one size fits all'. Habitus does not always develop from an individual's background, education, etc.; it is sometimes a result of hard work and effort towards making a change in their disposition or their habitus.

The most significant contributions of Bourdieu are his concepts of capital, field and habitus. Bourdieu uses the concept of capital to argue that cultural, economic, social and symbolic capital are used to gain power and also aid an exchange of resources. His argument about capital also gives an insight into the multiple sources of social power. The concept of field represents the sites of practice and serves as a link between the statutes that are in place and the daily activities, while habitus considers how individuals develop their attitudes.

For this thesis, the advantage of drawing on a Bourdieu-type approach to understand the experiences of governance officers is that it shows how the complexities of capital operate. Capital and habitus align themselves within the fields to impact on relationships that governance officers are involved in, and also their identity. Ultimately, this influences how governance officers ensure accountability at the local level of the NHS.

2.4 Justification of the study

The purpose of this study is to focus attention on governance officers as interpreted and understood through their as yet, unspoken and undocumented voices. Governance officers are an invisible group within the NHS and their voices and perceptions as they negotiate the space between clinicians and senior managers have not been heard. It is important to explore the lived experiences of governance officers and understand how they manipulate the space between two powerful staff groups: senior managers and consultants.

This study will explore how governance officers influence accountability in order to deliver high-quality patient care. Without this understanding, there is a potential risk to effective governance and patient safety. The enhanced knowledge and understanding should improve communication and team working and also tighten the relationships between governance officers, clinicians and senior managers. The delivery of quality service and treatment within the NHS depends upon this strong relationship. Looking at power relationships and how governance officers operate across borders and within spaces could identify elements of dysfunction and good practice.

How governance officers work within the directorates, maneuvering between consultants and managers, and managing inherent tensions in order to ensure accountability, is a key focus of this study. The role of a governance officer is to work within the governance strategy as filtered

down by the Department of Health. These governance officers have little or no clinical or higher-level managerial decision-making power, yet they are in the frontline for the sustenance of systems of accountability.

This research study is aimed then at exploring the voices of a specific group of governance officers and identifying their unspoken and hitherto undocumented opinions. It is about providing them with the space to tell their stories. As they occupy a pivotal position between two powerful staff groups, governance officers have to find a way of finding a balance in order to have some *rapprochement.* All parties need to feel that they can practice according to their values and beliefs.

The study aims to contribute to the body of existing knowledge by narrating the perspectives and experiences of this group of governance officers regarding how they ensure accountability at the local level, their relationships, their identity and their roles. It will also attempt to articulate how this group of governance officers views their world and hence, bring about an understanding of the intrinsic challenges that they face. A review of the group dynamics, i.e., the relationships within the group of governance officers and also relationships with their directorate colleagues, will provide an avenue for better understanding. Failure to understand the roles and conflicts encountered by governance officers could lead to sub-optimal communication between the areas providing the requirements of governance and those delivering patient care.

If clinicians do not engage fully with clinical governance, patient safety and quality of care could be jeopardised. Governance officers should be empowered to challenge systems or these systems will continue to fail. This study is, therefore, important in order to develop strategies to facilitate the governance officer role and to lay the foundation for new strategies towards enhancing the delivery of the governance agenda. By reviewing the dynamics of the governance officer team, i.e., the Community of Practice and the relationships within the group, an avenue for the better understanding of this group will evolve. Ultimately, the findings of the study could enhance the quality of patient care.

It is important to determine how governance officers negotiate the space between senior clinicians and managers – and how they ensure accountability at the local level. A review of the existing literature has enabled me to identify the gap in knowledge. The key problem of the study is that governance officers try to ensure that clinicians are accountable for their performance, yet little is known about their lived experiences, including the challenges that they face as they navigate the space between the senior clinicians and managers.

This integrative review has explored the available literature on clinical governance officers in the NHS and how they ensure accountability. There is a gap in the available literature on the role and experiences of clinical governance officers. This is also important, as it affects their identity. As

a result, the following research statement, objectives and questions have been generated.

2.5 Research statement, objectives and research questions

2.5.1 Research statement

To explore the lived experiences of governance officers as they negotiate the space between consultants and senior managers and ensure accountability at the local level of the NHS.

2.5.2 Objectives and research questions

Objectives

The objectives below have been put forward:

1. To explore governance officers' perceptions of their roles and their experiences.
2. To find out how governance officers carry out their role of ensuring accountability at the local level of an NHS Trust.
3. To identify the influence of power within the context of accountability in the NHS.
4. To conceptualise the role of governance officers in terms of a discrete Community of Practice within the wider landscape of NHS practice and accountability.

Research questions

The literature review has prompted the following research questions:

1. How do clinical governance officers narrate their roles?
2. What is it like to be a clinical governance officer within the UK NHS accountability framework?
3. How do clinical governance officers describe and experience accountability mechanisms in their local environments?
4. How do power dynamics influence accountability within the NHS?
5. How does the practical engagement of the governance officer affect their sense of self?
6. How can the role of governance officers be conceptualised in terms of a discrete Community of Practice within the wider landscape of NHS practice and accountability?

2.6 Summary of the chapter

This chapter has reviewed the available literature on clinical governance officers and their role in ensuring accountability at the local level of the NHS. The concepts of accountability and governance were reviewed. Role theory was identified as an appropriate theory with which to underpin the study. Concepts of role theory such as consensus, role conflict and role overload have been discussed. The chapter also identified Foucault's

theory of power as relevant in understanding how power dynamics influence the role of governance officers. In addition, Bourdieu's theory of habitus was identified as useful for understanding the impact of capital and habitus on the identity of governance officers within a field.

The chapter has highlighted that there is dearth of literature on governance officers. This substantiates the need for more understanding of this group of staff. The gap in the existing literaure has been highlighted and a justification for the research study has been provided. In addition, the research statement, research objectives and research questions of the study have been presented. The next chapter discusses the methodology of the research study. The settings of the study and my positioning are discussed. The chapter then focusses on the data collection tools and the methods of data collection.

Chapter Three

Methodology

3.1 Introduction

The previous chapter reviewed the available literature on governance officers and how they ensure accountability at the local level of the NHS. It also reviewed the theories that might help in understanding governance officer roles. This chapter begins with a discussion of the settings in which the study took place. It then discusses my positioning as an insider/outsider. It justifies the research design and research instruments that were employed to address the research questions. How credibility and trustworthiness were ensured throughout this process is discussed. In addition, ethical issues relating to the study are reviewed. Finally, the approach employed in the data analysis is discussed.

3.2 The setting for the study – The NHS Trust

The setting for this study is an NHS Trust located in a cosmopolitan urban centre within the West Midlands. For the purpose of this study, it will be referred to as H City. H City has a population of *circa* 250,000 people (UK Census, 2011). The population is ethnically diverse and the health indicators are lower than the national average.

The area has socio-economic challenges. H City is one of the 20% most deprived areas in the UK. About a quarter of its children live in low-income families (Public Health England, 2018). There are higher levels of

unemployment, shorter life expectancy and lower living and working conditions than the UK average. The disparity in the determinants of health in H City compared with other city areas means that the quality of health is relatively poorer here than the UK average. Table 13 shows the health profiles of H City.

Life expectancy for males and females (average number of years an individual is expected to live) is 77.2 and 81.3, respectively. This is lower than the UK average of 79.6 and 83.1 for males and females. Infant mortality (number of deaths per 1000 during the first year of birth) is higher (5.6) in H City than the average for UK. The teenage pregnancy rate, the number of women under 20 years old per 1000, is higher in H City (1.0) than the UK average of 0.7. Other indicators, e.g., obesity, number of GCSEs achieved, employment rate and Deprivation Score are worse in the area of study than the UK average.

Table 13: Health profiles for area of study
(Adapted from Public Health England, 2018 – health summary for H City)

Indicators	H City	Average in UK
2014 –16 Life expectancy (male)	77.2	79.6
2014–16 Life expectancy (female)	81.3	83.1
2014 –16 Infant mortality rate	5.6	3.9
2014 –16 Under 75 mortality rate (all causes)	440.7	333.8
Teenage pregnancy	1.0	0.7
Obesity in children	26.7	20.0
GCSEs achieved	52.1	57.8
Employment rate (16 – 64yrs)	65.4	74.4
Deprivation score (IMD* 2015)	33.2	21.8

*Index of Multiple Deprivation

People's status and lifestyles influence their health. The level of education and awareness of the populace in an area influences their knowledge of health-related matters (Marmot, 2015). Where education and awareness are low, this makes the populace more passive and less likely to have an internal locus of control. They are less able to be adequately responsible for their own health or self-advocate and navigate their way through the system. The implementation of robust governance structures would potentially ensure that the care that is provided to the patients presenting is of a high quality.

The NHS Trust for H City, H City NHS Trust for the purpose of this study, is one of the busiest and largest acute and community providers in the region. It is located on three sites and it serves the city and its environs. There are more than 850 beds on the main site and the hospital employs more than 8,000 staff. Both inpatient and outpatient services are provided. These are categorised under three clinical Divisions: surgical, medical and ambulatory Divisions. Under each Division, are directorates which are made up of a group of specialties. The directorates include Obstetrics and Gynaecology, Neonatal and Paediatric services, Trauma and Orthopaedics, Cardiac and Intensive Care, Oncology and Palliative Care, 24-hour Emergency Services and Diagnostic Services. The Trust houses a number of regional specialist units where patients from across the Black Country are referred. It is a teaching hospital and it provides training for medical and nursing students from regional universities (Annual Report, 2019/20).

The Trust's vision is:

> *'To be an NHS organisation that continually strives to improve the outcomes and experiences for the communities we serve'*
> (2019/20 Annual Report, p. 11).

The Trust values state that it is dedicated to prioritising the safety of those under its care, and also growing a reputation of excellence. The Trust was rated as 'Good' overall by CQC on two consecutive occasions.

A performance analysis in the Trust's annual report showed that there are structures in place to monitor indicators. The 2019–20 report

highlighted areas of poor performance. For instance, serious incidents included: diagnosis (18); treatment delays (13); infection-related (10); sub-optimal care (6) and Never Events (2). Further results are:

- Cancelled operations at short notice – 0.65% (target <0.8%)
- 18 weeks referral to treatment incomplete pathways = 84.32% (target 92%)
- Patients treated/admitted from ED within 4 hours = 85.91% (target 95%)
- Ambulance handover = 1,547 (30–60 minutes) breaches and 221 (>60 minutes) breaches
- Patients with a diagnosis of cancer who wait no longer than 62 days = 59.17% (target 85%).

The above information shows that the Trust seemed to be failing to hit quite a few targets, even though there is criticism of the NHS for being too target-driven, as discussed in the Francis Report. Nonetheless, the report informs the need for strong lines of accountability.

The participants for this study are governance officers in the H City NHS Trust where I am also employed as a governance officer. Clinical governance officers in H City NHS Trust are administrators employed within the NHS who have taken on a relatively new, previously unexplored role. The nine governance officers employed by the Trust are centrally located in an open plan office where they coordinate and facilitate the delivery of governance processes and outputs such as performance updates and reports. Table 14 shows the workstreams that

are undertaken by the governance officers, while Appendices 1 and 2 show the Governance Team structure and the job description of governance officers, respectively.

Table 14: Governance workstreams and tasks undertaken by governance officers (modified from a work-based document)

Workstreams	Description of Tasks
Clinical Audit	To liaise with directorates to develop an annual audit plan
	To ensure that all audits are registered on the database and that they are completed within timescales
	To ensure that the audit database is up-to-date with complete and accurate information
	To meet with audit convenors regularly
NICE /National Guidance	To update and manage the NICE database
	To discuss progress at governance meetings
Risk Management	To review the risk registers and discuss at governance meetings
	To liaise with directorates to update the risk register
Incident Management	To monitor incidents, highlight trends and produce reports
	To ensure good incident management
	To advise clinicians on incident management

Workstreams	Description of Tasks
Serious Untoward Incidents (SUI) Actions	To ensure that action leads are aware of their actions
	To monitor SUI actions with directorates and ensure completion
Shared Learning	To ensure that shared learning/RCAs/synopses are discussed at appropriate governance meetings
Duty of Candour	To ensure that the Duty of Candour is applied, where appropriate
External Visits/Quality Review Visits	To manage external visits on a central database
Integrated Governance Reports (IGRs)	To present IGRs at governance meetings
Patient information leaflets	To support directorates with the ratification process for patient information leaflets
Information Governance (IG)	To liaise with directorates to manage IG incidents

3.3 Positionality – the insider/outsider role

I am a governance officer and governance officers working in one NHS Trust in England have been chosen as the participants for the study. All of the nine governance officers that were working within the Trust that I am employed at during data collection, were included in the study.

My familiarity with the environment of study meant that I had intimate knowledge on the subject area. I was able to understand the role of the governance officers from the inside and from their point of reasoning. I also had a better understanding of the culture and the politics of the environment. My choice of the research study, the title of the dissertation and the research questions were influenced by my position as an insider. Being an insider also influenced the data collection (Flick, 2009; Robson, 2011; Pope and Mays, 2020). This potential bias was avoided by ensuring that the data collection methods were as transparent as possible and also by maintaining a neutral position during the data collection sessions.

Positionality, whether a person is an insider or an outsider in a research study, has an influence on the outcome of the research study (Costley *et al*, 2010; Greene, 2014; Polit and Beck, 2018). An insider researches a group that they belong to, while an outsider is a person who does not belong to the group that is being researched (Breen, 2007; Costley *et al*, 2010; Gair, 2012; Braun and Clarke, 2013; Greene, 2014). I am an insider because I am employed as a governance officer in the organisation where this study took place. I share group identity with the

participants. I am also a PhD student from a university, carrying out a research study on governance officers.

Insider and outsider perspectives are described using the ethnographic terminologies, emic and etic, as first designated by Pike (1967). Over the years, there has been confusion over the definition of these words (Heartland *et al*, 1990; Willis, 2007; Olive, 2014). The emic perspective studies behaviour from the inside of a system, i.e., through the eyes of the individuals being studied. The etic perspective studies behaviour from outside. However, as everyone is involved in the research process, it leaves a query as to whether anyone is truly an outsider.

My positionality as an insider had its advantages and disadvantages (Bonner and Tolhurst, 2002; Dwyer and Buckle, 2009; Costley *et al*, 2010; Greene, 2014). I was already acquainted to the environment, as I had an intimate knowledge of the social setting of the work environment which was also the field of study. I was aware of the culture and politics of the environment and I had easy access to the relevant people who could facilitate the approval of the study and enable progress. This made the ethical approval and data collection processes less stressful (Bonner and Tolhurst, 2002).

It is possible that the participants were more truthful, because they knew that, being one of them, I was aware of the actual situation. It meant that I was at ease with them during the collection of the data. I

understood much of the context of the participants' comments and I was able to empathise with them. The participants and I had shared experiences and a common understanding of the governance officer role. As an insider, I felt that I had some personal authority because I had a strong insight into what the participants were talking about.

However, having an insider position had possible negative effects. I had to combine the role of both researcher and colleague. There was the potential for loss of objectivity since I had close contact with my colleagues and the institution. It could be argued that I was too steeped into the role of the governance officer to actually 'understand' it. There was the potential that, as an insider, during the data collection and analysis I would not be in a suitable position to control and capture salient issues about the study, as I would see them as normal (Costley *et al*, 2010; Sharan and Tisdell, 2015).

Being an insider with prior information could cause researcher bias that may influence the overall outcome of the research study. Bias has been described as that element within a study design that could allow the results to be different from the real values (Stewart, 2002; Parahoo, 2014). Bias affects the credibility and reliability of a study. I felt uncomfortable asking the participants some questions for which the answers were obvious. At the beginning of the data collection, I explained to the participants that they might be asked questions for which the answers were obvious; this was because the study is about hearing the

voices of the governance officers. By telling their story in great clarity, the governance officers would provide the robust data required to provide a thick description to answer the research questions and thus reduce bias. Geertz (2000) states that thick description is used to:

> *'uncover the conceptual structures that inform our subjects' acts, the 'said' of social discourse, and to construct a system of analysis in whose terms what is generic to those structures, what belongs to them because they are what they are, will stand out against other determinants of human behaviour'* (Geertz 2000, p. 27).

Such thick descriptions, including background context have the potential for revealing complexities (Geertz, 2000; Silverman, 2016).

Throughout the study, I was conscious of the tension involved in being an insider and a researcher. The participants might not have always disclosed important information to me, as they might have thought that I was aware of these issues already. In some cases, the insider could be given access to sensitive information that should not be disclosed. Overfamiliarity could possibly cause some participants not to take my requests seriously and this could perhaps create issues relating to attendance, attitude and responses during the interview – informant bias.

Insider bias was mitigated by trying to avoid asking leading questions and by not imposing my views over those of the participants. In addition, I tried as much as possible to understand what the participants were saying by probing during data collection. In addition, I put in a thick description of events, inserted quotations to limit subjectivity and tried to be reflective.

I remain of the view that the researcher is a relevant part of the research. It is not easy to capture and fully understand what goes on in a person's culture without actually being a part of it. Therefore, my aim was to be as close to the situation being discussed as possible, and to genuinely get a clear representation of what they were thinking.

3.4 The research questions

The six research questions for the study are:

1. How do clinical governance officers narrate their role?
2. What is it like to be a governance officer within the UK accountability framework?
3. How do clinical governance officers describe and experience accountability mechanisms in their local environments?
4. How does the practical engagement of the governance officer affect their sense of self?
5. How do power dynamics influence accountability within the NHS?
6. How can the role of governance officers be conceptualised in terms of a discrete Community of Practice within the wider landscape of NHS practice and accountability?

The choice of research questions was influenced by my ontological and epistemological assumptions. This also influenced the choice of data collection, i.e., individual semi-structured interviews and a focus group. These data collection methods allowed the participants to share their

experiences. The research questions that were developed following the literature review were shaped by my knowledge and also by my experience of the governance officer role.

I formally transferred from a professional doctorate course to a PhD course in 2017 and the title of the dissertation was changed from, *'Caught in the Middle: hearing the Voices of Governance Officers in an NHS Trust'* to: *'Unresolved Tensions? Hearing the Voices of Governance Officers in an NHS Trust'*. It has since been changed to *'An Exploration of the Roles and Experiences of Governance Officers in ensuring Accountability in an NHS Trust'.* This new title offers possibilities for me to focus on the lived experiences of governance officers and how they perceive their environment. The focus of the dissertation shifted towards exploring how governance officers ensure accountability at the directorate level of an NHS Trust. The study will also explore how power dynamics are played out within the governance network and the theoretical perspectives underlining it.

3.5 The research process

3.5.1 The research design

How my ontological and epistemological assumptions influenced the research study have been explained in Chapter 1. The research questions determine the research process and it was important to design an appropriate process to effectively answer the research questions. Qualitative research studies were most suitable for answering these questions. Qualitative studies seek to describe and interpret naturally-occurring phenomena in the social world and data could be in the form of stories, observations, etc. (Patton, 2015). These studies could be based on open-ended interviews, direct observations or written communication. In contrast, quantitative research studies involve experiments, measurements and statistics. The philosophical assumption behind quantitative research is positivism. The reality here is external and objective (Bryman, 2016). This type of research study includes the testing of theories by examining the relationship between variables. The variables are measured using instruments and the numbered data are analysed statistically.

Patton (2015) describes how qualitative research contributes to knowledge: it conveys meaning that people place on their experiences, perceptions, circumstances and events around them. This feature has been described as a major strength of qualitative studies, which are most suitable for explaining the lived experiences of people. As the nature of

this study would influence the research methodology, a constructionist paradigm was chosen as the form of qualitative research. The assumption here is that knowledge is obtained from the interaction of the researcher and those who are being studied.

The different research designs that could be used in this study include case studies, ethnography, phenomenology, etc. Case studies provide detailed analysis of a case. These in-depth studies focus on specific entities such as persons, communities, organisations, activities, etc., which are bound in time. Case studies provide thick description and they use a variety of data collection methods – both quantitative and qualitative to investigate phenomena. Issues such as circumstance, development and history of the case are analysed (Bryman, 2016; Flick, 2018; Polit and Beck, 2018; Baron and McNeal, 2019).

Ethnography is derived from the Greek word, 'ethno' which means culture, and 'grapho' meaning writing (Ladner, 2016). It is an approach that involves studying human behaviour and cultures in a natural environment. The meaning underlying this is then interpreted using a thick description. It also aims at understanding social processes by gaining an insight into the social reality of groups of people via their words and actions (Cousin, 2009; Parahoo, 2014; Flick, 2018; Polit and Beck, 2018). Ethnography was not seen as an appropriate design because it would not answer the research questions of this study. The intention of this study is to hear the voices of the governance officers – not to

examine their behaviour or culture. I was also not keen on being a participant-observer in the research study. Furthermore, time restrictions would not have made this possible.

I decided to employ phenomenology, which relates to how individuals make sense of their world (Bryman, 2016). This would give the governance officers a voice and enable me to explore and interpret their lived experiences using rich descriptions.

Greenhalgh and Taylor (1997) state that:

> *'Researchers attempt to make sense of, or interpret phenomena in terms of the meanings people bring to them and they use holistic perspectives which preserve the complexities of human behaviour'* (Greenhalgh and Taylor 1997, p. 740).

Phenomenology is derived from the Greek word, 'phainomenon,' – this means 'appearance'. The roots of phenomenological research practice are located in the works of philosophers like Husserl and Heidegger (Heidegger, 2005; Husserl, 2012; 2013).

Phenomenology could be described as the study of entities as they appear to us; not as they exist in reality (Heidegger, 2005; Parahoo, 2014). It entails exploring the essence of the phenomena that are experienced by those who are being studied. The assumption is that some knowledge can be obtained from exploring the lived experiences of people. Phenomenologists, therefore, attempt to understand these lived experiences and interpret them from the point of view of the studied population (Bryman, 2016; Polit and Beck, 2018). This is appropriate in

cases that have not been well-explored such as the role of governance officers and how they ensure accountability.

The philosophical ideologies of Husserl and Heidegger have influenced my leaning. Husserl explains the experiences that individuals undergo scientifically by eliminating all influence of preconceptions or assumptions, including personal experiences. He does this by placing in 'brackets' all other experiences in order to enable the researcher to focus on the particular experience through intuition, imagination and also the structures in place – transcendental phenomenology. Heidegger, on the other hand, refutes the notion of bracketing, stressing that objects cannot be separated from their context. He attempts to provide a comprehensive meaning to existence by questioning the meaning of 'being'. He asserts that the main way of acquiring knowledge on existence lies in existing, i.e., in being – hermeneutic phenomenology.

What is important, however, is to show how the phenomenological approach that developed on the philosophers' foundations is used here. Finlay, for example, sets out a debate on how to approach phenomenological research. Issues raised include where to place the limits around phenomenology, the amount of interpretation and whether subjectivity should be in the forefront (Finlay, 2009). Horrigan-Kelly *et al* (2016) point to the importance of highlighting everyday ordinary existence to the study. My approach draws on these emphases and arguments by exploring the lived experiences of the governance officers

whilst providing thick descriptions of their experiences and acknowledging the role of the researcher.

Such a phenomenological study can illuminate salient issues by giving governance officers a voice through a detailed exploration of their roles, responsibilities and the relationships between groups and individuals and how they experience them. The aspect of phenomenology that is explored here is 'lived human relation' – relationality (Polit and Beck, 2018). Being a qualitative study with interviews as the source of data collection, phenomenology also recognises the co-participation of both the researcher and the participant.

In this study, semi-structured individual interviews and a focus group were seen as appropriate methods to explore the governance officers' views on their roles and how they ensure accountability. The research study becomes a collaborative piece of work between the governance officers and the researcher. Some other types of data collection such as observation or document analysis were considered. An option would have been to attend meetings with governance officers and observe the interactions that took place between themselves, the consultants and senior managers. However, these would not be appropriate in answering the research questions. The reasons why individual interviews and a focus group were chosen are discussed in the next sections.

3.6 Data collection tools

3.6.1 Individual interviews and focus group

3.6.1.1 Individual interviews

Individual interviews were chosen as the data collection method because they allow for the possibility of rich insights into experiences, perceptions, feelings and knowledge (Patton, 2015; Bryman, 2016; Silverman, 2016). For this study, individual interviews enabled the exploration of the role of the governance officers because the interviewees could express their opinions and feelings in depth, while also allowing the researcher the opportunity to explore issues. The interviews enabled the participants to tell stories about their roles in a robust, yet relaxed fashion in order to fully address the research questions. Individual interviews are also ideal for studies where sample numbers are small.

The interviews were semi-structured; they were facilitated through the use of an interview schedule (May, 2005; Cousin, 2009; Parahoo, 2014; Flick, 2018). This was developed based on the research questions. Interview schedules provide standardisation and comparability to the research design. Furthermore, clarification and elaboration were ensured by probing which enhanced rigor, credibility and transparency (May, 2005; Cousin, 2009; Parahoo, 2014; Flick, 2018).

Credibility refers to the level of trustworthiness or certainty of the data. This is an indication of the extent to which the observations of a study actually match the theoretical concepts. It relates to how the findings of

a research study are linked with reality in order to portray the truth (Swanson and Holton, 2005; Bloomberg and Volpe, 2016; Bryman, 2016; Polit and Beck, 2018). Credibility is about whether the research questions that the study claims to have answered were actually answered. It relates to whether the findings have made sense, are free from error and misrepresentation, and if they are credible to the participants.

As an instrument of enquiry, the credibility of the research study was, firstly, influenced by my background, experience, skills, training, and also how I engaged in the research process (Patton, 2015; Flick, 2018). I had a good level of knowledge on the subject matter and had read widely on the research process which possibly reduced bias. Having a good grasp of the concepts was important in ensuring that the findings are well-aligned to the concepts. To ensure credibility, I provided a clear justification for the study. The research questions were well-defined and they focused on the aim of the study. The review of the available literature was systematically and comprehensively done.

In qualitative studies, triangulation is a recommended means by which multiple data sources, methods or theories are used in order to achieve a more comprehensive understanding of what is being studied (Parahoo, 2014; Bryman, 2016; Flick, 2018; Polit and Beck, 2018). It is argued that a good research study will address research questions with more than one method.

Following the individual interviews, more questions arose about how the governance officers ensure accountability at the local level. This required further data collection to address the research objectives and questions. Transferring to a PhD provided the scope and extra wordage to do this. The focus of the study was altered to include how governance officers ensure accountability at a local level. I, therefore, added some research questions relating to accountability and a focus group was carried out to answer those questions. The governance officers that participated in the individual interviews had been informed from the outset, i.e., when providing them with information about the individual interviews, that they might be requested to participate in a focus group. This triangulation provided a degree of confirmation to the research questions that had been answered by the individual interviews.

The triangulation of methods provided converging findings that enhanced the credibility of the study (Patton, 2015; Silverman, 2016). With triangulation, rigour is ensured and limitations in research are minimised (Bowling, 2014; Pope and Mays, 2020). This reduces bias, as multiple sources of information counterbalance availing strengths or weaknesses. Additionally, the researchers tend to know more about a study as a result of triangulation and this provides more confidence around the findings. Some would, however, argue that the introduction of another method into a research study will 'adulterate' the advantages of the original

method by diverting the focus and concentration that is required to address the original method.

Credibility was enhanced by prolonged engagement with the participants during the individual interviews and the focus group. Credibility was also ensured by being sensitive during data collection and utilising good interviewing techniques. It was important to listen more and talk mainly in order to prompt the participants on. The interviews and focus groups were recorded and transcribed. The transcripts were returned to each of the participants for further clarification and so that they could confirm that the statements were true reflections of their views. I constantly reflected on the research process, my values and behaviour and those of the participants. Reflexivity further enhanced the credibility of the study.

Individual interviews are subject to informant inaccuracy, i.e., some of the participants may not accurately discuss what they actually do (Bernard, 2013). The interviews can also be time-consuming, i.e., preparation, transcription and data analysis. In addition, interviews require a good level of skill to be able to explore ideas while keeping focus on what is being said by the participant. The research questions served as a guide and enhanced credibility. The research questions that were addressed by the individual interviews and the focus group are discussed on page 132. In order to ensure credibility and confirmability, practice interviews were done as explained on page 159.

3.6.1.2 Focus group

Focus groups are well-established data collection methods. They are interactions between one or more researchers and more than one respondent in order to collect data. The respondents have similar roles or ideas and they discuss a topic or issue in depth. Focus groups look at how people think and why they think the way they do (Krueger, 1998; Krueger, 2000; Parahoo, 2014; Bryman, 2016; Flick, 2018).

Focus groups involve observing how a group of participants interacts and communicates during discussions and how they construe topics of interest in order to generate data. The aim of the focus group for this research study was to pull ideas together and provide an elaborate insight into the governance officers' perceptions, experiences and underlying beliefs. This helped to develop a robust understanding of their role in ensuring accountability at the local level.

As they interact with one another in a social environment, the participants generate ideas and bring to the fore, issues that are important. Although the participants were expected to argue with one another and challenge each other's views, they also built upon other members' views. Focus groups allow the sharing and comparing of ideas (Krueger, 2000).

Focus groups are cumbersome to arrange, as it is not easy to get all the participants together in one space at the same time. Other limitations of focus groups (and individual interviews) are observer interference and

social desirability bias, whereby some participants might slightly exaggerate or deny some actions so as to look good or try to make their story more interesting. Attempts were made to overcome this by telling the participants that anonymity and confidentiality will be maintained. In addition, the questions that were asked were carefully framed to reduce social desirability bias.

There was a tendency for some participants to speak at the same time. This prevents clarity during recording, while some individuals tend to dominate discussions. As the moderator of a focus group has less control than an interviewer in an interview, this could, sometimes, result in the discussion of irrelevant issues. The interviewer has to be conscious of this and keep the participants focused.

The value of the focus group was enhanced by asking the participants questions that were thought through, so that they could provide the required information on governance officers. A practice focus group was done as described in the following section. A good level of rapport during the focus group which comprised going over what was said with the participants to ensure accuracy and exploring more into the participants' experience also established credibility. As a result, sufficient data were collected to ensure that the findings and the concepts were aligned.

Pilot studies

Pilot studies were carried out to ensure that the structures of the individual interviews and the focus group were appropriate and that the probes minimised the level of bias and error (Stewart, 2002; Parahoo, 2014; Polit and Beck, 2018). The pilot sessions provided experience, enhanced my confidence and helped to check the efficiency of the recording of discussions.

The essence of having pilot individual interviews was to assess the efficacy of the data collection tools in addressing the research questions (Gerrish *et al*, 2015). The pilot sessions also enhanced the credibility and reliability of the data collection methods. Piloting ensured that the issues that were discussed during the interviews would be appropriate in answering the research questions. Open-ended questions were asked and they enabled me to obtain detailed explanations from the participants based on their understanding of their experiences.

The first individual interview that was conducted with a governance officer served as a pilot. This took place in August 2015 and it was conducted with my colleague, Governance Officer 1 (GO1). Issues such as how the governance officer felt about his role, his experience of being a governance officer and the challenges he faced were discussed. Open-ended questions were framed on schedules to generate a focussed discussion (Appendices 3 and 4). Generally, the interview schedules addressed the research questions, but a few minor amendments were

made. GO1 mentioned that a question that asked what it is like to be a governance officer had not been put across explicitly. The first question of the interview schedule was, therefore, amended to ask: *Tell me what it is like to be a governance officer?*

The pilot focus group was carried out to test the data collection process for the actual focus group with the governance officers and to provide the required confidence to coordinate and manage a focus group. This took place on the university campus. Although the intended sample for the focus group was governance officers working in an NHS Trust, the pilot focus group included persons who had some prior knowledge of governance in the NHS. This involved my two supervisors and two PhD students who had been invited by my Director of Studies.

The schedules were made up of four kinds of questions: an opening question, key questions, an ending question and a final question. In order to ensure that the interview schedules were satisfactory, these questions were scrutinised by the supervisors and suggestions for amendment were made. The suggestions included reducing the time of the focus group to an hour and cutting down on the number of questions. Feedback and suggestions from the participants on my moderating skills in preparation for the actual focus group were solicited after the pilot session.

The feedback from the focus group included good use of probing skills and appropriate steering of the direction of the discussion. In addition, it

was noted that the facial expressions and body language of the participants should be observed in subsequent interviews. Another issue raised was that the participants should have been given information letters before the focus group took place, so that they could have ample time to assimilate the contents. Lastly, I was advised that some questions were ambiguous – the use of simple words and direct questions was suggested. Necessary amendments were made after the pilot individual interview and the focus group. The number of questions for the focus group was reduced to what could be accommodated within one hour.

Data from pilot study interviews are not usually analysed with the main results (Leon *et al*, 2012; Gerrish *et al*, 2015). This is because modifications would have been made to the main study following the pilot. For this study, the data from the pilot study were included in the final analysis because an amendment was immediately made and the data that were provided by GO1 were rich. Furthermore, the sample size was small and disregarding the data from the pilot study would have impacted upon the final analysis. Having the pilot interviews strengthened the reliability of the study and improved its quality. The intention was to reduce any form of bias during data collection and analysis while exploring the governance officers' role of ensuring accountability. The presentation of the findings and the interpretation were also areas for evaluating credibility of the study.

3.7 The sample: individual interviews and focus group

The choice of the NHS Trust for the research study was based on convenience, as it is my place of work. One disadvantage of convenience sampling is that it does not give representative samples and it is not easy to replicate (Stewart, 2002). It was assumed that the research process would be smoother on familiar terrain.

The samples for the individual interviews and the focus group were from a single site study. This was all the governance officers who were employed within the study centre. The inclusion criterion was that the governance officers should have been working in the NHS Trust at the start of the data collection period. The sample was purposive – the participants were colleagues who had been selected and invited to participate in the study based on their roles as governance officers working in an NHS Trust. This group was chosen because the project is about hearing their story and exploring their views and attitudes. The expectation was that they would provide a wealth of information that would fill the gap in literature relating to governance officers.

Eleven governance officers were invited to participate in the individual interviews. However, eight governance officers participated – one governance officer was away on long term sickness, another governance officer had left the NHS on health grounds, while the third governance officer had left the Trust for another job. In order to help to minimise social desirability bias, the participants were informed that there were no

right or wrong answers. Some of the participants were passive and to ensure equal participation, questions were directed towards them.

A researcher should not always expect that situations will unfold according to plan (Robson, 2011). When the focus group was being planned, there were six governance officers in employment and they were all invited to take part. Five governance officers took part in the focus group, as one governance officer had to take the day off work for personal reasons. The participants for the focus group were not all the same as those for the individual interviews, as some of the participants had left the Trust and new governance officers had been employed.

3.8 Ethical considerations

The main ethical considerations for the study were: voluntary participation, informed consent, confidentiality, anonymity, principle of beneficence and communicating the results. Ethical principles and guidelines were adhered to while undertaking the research study (DHEW, 1978; World Medical Association, 2013; Gerrish *et al*, 2015; Dove, 2020).

Before obtaining the Trust's ethical approval for the study, formal approval was obtained from the Head of the Governance and Legal Services Department. A research proposal was then submitted to the Research Ethics Committee of the Faculty of Education, Health and Wellbeing of the university and also the Research and Development (R&D) Department of the NHS Trust. Approval was sought from the

Integrated Research Application Service (IRAS). This was an arduous task. However, the staff in the R&D Department were very helpful, co-operative and friendly. Being a member of staff facilitated the ethical approval process. The R&D Department was in a building adjacent to the my office. This made it easy for meetings to be arranged and the staff in the R&D Department were able to contact me via phone and e-mail.

Once ethical approval had been obtained from the university and the NHS (Appendices 5 and 6), plans for the data collection commenced. According to the General Data Protection Regulations (Data Protection Act, 2018), prospective participants were provided with the relevant information about the research study so that informed consent could be sought (Fink, 2013). This was done in writing (Appendix 7: Participant Information Sheet; Appendix 8: Informed Consent Form; Appendix 9: Letter to governance officers). The documents explained details of the study, stating that participation was voluntary. The letters also stated that the interviews would take about an hour and that although they would be tape-recorded, confidentiality and anonymity would be ensured.

The participants were made aware of their right to withdraw from the research study at any time. All data were collected, managed, processed, stored and disposed of in accordance with the General Data Protection Regulations and the NHS Code of Confidentiality (DH, 2003; Data Protection Act, 2018). Data were securely stored on a password-protected laptop computer and hard copies of documents, such as

consent forms, transcripts, etc. were scanned and the paper versions were destroyed (Gerrish *et al*, 2015).

Information was obtained from participants on a 'need-to-know' basis. There were no participant-identifiable details, such as names and addresses on documents. Code numbers, e.g., GO1, GO2, etc., were used to ensure confidentiality. The tapes that were used for the recording of individual interviews and focus group were stored securely.

The well-being of the participants was of priority and I focussed on maximising the benefits and minimising harm. Although debriefing sessions were planned, no distress was reported as having been caused to the participants.

3.9 Recruitment of the participants

All the governance officers who were employed in the NHS Trust were invited to participate in the individual interviews. The aim was to collect rich data from this group. It was felt that having individual interviews with the governance officers will enable their responses to be forthright. Once Trust approval had been obtained, the governance officers and line managers were formally informed of the research study at a team meeting. A request was made for their support. They all willingly agreed to participate in the study. The governance officers were informed that a participant information sheet and a consent form would be sent to them. They were then approached for a suitable time to conduct the interviews.

3.9.1 Participants' demographic characteristics

Individual interviews

Eight governance officers took part in the individual interviews which were held between August 2015 and May 2016. Table 15 sets out the basic demographic characteristics of the participants that took part in the individual interviews. To ensure anonymity, the demographic characteristics of the participants in Tables 15 and 16 are not presented according to the numberical order of the governance officer codes.

Table 15: Participants' demographics for individual interviews

Age Range	Gender	Qualification	Years of Experience
50 – 55 years	Female	BA Business Management	4 years
30 – 35 years	Male	BSc Medical Sciences	8 months
40 – 45 years	Female	N/A – Extensive experience	2 years
50 – 55 years	Male	BSc Business Information Systems	4 years
30 – 35 years	Male	BSc Accounting	4 years
30 - 35 years	Female	BA Psychology	6 months
50 – 55 years	Male	BA Social Sciences with Politics	4 years
45 – 50 years	Male	BSc Applied Biology	4 years

Five of the participants were male and three were female, their ages ranged from 26 to 52 years old. They had diverse academic qualifications and ethnicities. They all had academic qualifications up to university level, with the exception of one governance officer who had extensive experience working in the Governance Department. They had spent varying numbers of years in their roles. Five governance officers had spent four years in the role, one governance officer had spent a year and two had spent less than a year.

Focus group

Table 16 presents the demographic details of the participants for the focus group.

Table 16: Participants' demographics for focus group

Age Range	Gender	Qualification	Years of Experience
40 – 45 years	Female	N/A – Extensive experience	4 years
30 – 35 years	Female	BA Psychology	2½ years
50 – 55 years	Female	Diploma in Business Studies	6 weeks
50 – 55 years	Male	MSc Information Sciences	1 year
30 – 35 years	Male	BSc Accounting	6 years

As seen from the table, three of the participants were female while two of them were male. Their ages ranged from 30 to 54 years old. The

participants had spent 6 years, 4 years, 2½ years, 1 year and 6 weeks, respectively, as governance officers. They all had educational qualifications up to university level, with the exception of one participant who had extensive experience as a governance officer.

Informal discussions were held with my line manager about the focus group before making a formal request. This method of data collection was more favourable to the management team than the individual interviews because it saved on time away from work; it was a single forum where all the governance officers could express their opinions at the same time. Some of the governance officers who participated in the individual interviews had left the Trust, while three new officers had joined the team. The total number of governance officers in the department was six and they were all invited to participate in the focus group.

The governance officers that had taken part in the individual interviews were thanked for their past support and they were asked if they would like to participate in the focus group. Those that had not taken part in the individual interviews were informed about the study. They all expressed a keen interest in participating in the focus group. Participant information sheets and a consent form for the focus group were then distributed to them (Appendices 10 and 11). A suitable date was sought and the 12th of November 2018 was convenient for all the governance officers.

3.10 The data collection process

3.10.1 Individual interviews

Data were collected from participants between November 2015 and May 2016. Arranging a mutually convenient time for each interview was cumbersome due to the heavy workload of the governance officers and the need to prioritise their responsibilities. Although the interviews were arranged at the participants' convenience, some of the interviews were postponed on many occasions.

I had to be flexible with the meeting times for the interviews and it was advantageous that the venue of the meetings was within close proximity to the governance office. It was felt that conducting the interviews with the governance officers in their natural environment, i.e., within close radius of the governance office and certainly within the hospital premises, would be convenient. It would make them relax and it would encourage the smooth operation of the interviews. Most of the interviews conveniently took place in a small meeting room opposite the governance office. When this meeting room was not available, meetings (two meetings) were held in the Boardroom. The aim was to consider settings that were quiet and free from disturbance by others (Kitzinger and Barbour, 1999; Bryman, 2016). This was to ensure confidentiality and anonymity. It was also important to ensure smooth conversations and maintain privacy and silence during the interviews, because the interviews were recorded. Prior to the commencement of each interview,

the participants were reminded of the purpose of the research study, stating that their participation was voluntary and that the interviews would be tape-recorded. On average, the interviews lasted one hour and fifteen minutes.

Conducting the interviews involved listening attentively. A conscious effort was made to focus on what the participants were saying and also to maintain eye contact, nod and smile occasionally. It was felt that this encouraged the participants to relax better, talk willingly and clarify issues better. Notwithstanding, prompts were given and further questions were asked in order to obtain information from the governance officers on their experiences. This was done using the interview schedule (Appendix 3) which ensured that specific issues were covered.

3.10.2 Focus group

The participants were individually reminded of the focus group a day before the event. This took place in the Boardroom which is located downstairs of the Governance Department. It was a convenient setting because it had a large table, comfortable chairs and a flip chart. I arrived at the venue about 20 minutes to the start time and set up three audio cassettes. A cassette was provided by the Director of Studies, another was for the Trust and the third one was mine. Three tape recorders were used in order to be absolutely sure that some recording will be available.

The recorders were positioned such that they would capture what was being said by all the participants.

Once the participants had settled down in the Boardroom, they were welcomed and thanked for attending the focus group. The seating was amended so that everyone was in close proximity to one of the three tape-recorders. The recorders were switched on and a brief introduction to the focus group was given, restating the purpose of the session and the essence of recording the discussions. The participants were also reassured of confidentiality and anonymity. Finally, the time frame for the session was reiterated.

The focus group schedule was used to facilitate the discussions which lasted 45 minutes. When presenting focus group data, it is important to report on the interactions between group participants (Krueger, 1998). These interactions could be either complimentary or argumentative. Differences in opinion should be analysed by the moderators who explore with participants, the factors that may lay behind them. Some observations were made (Appendix 12). There was an atmosphere of informality and friendliness as the participants were colleagues and they were well-known to one another. There was, therefore, healthy group dynamics. A genuine desire was noticed in the composure of the participants to be of assistance. A slight anxiety was observed on the faces of some of the governance officers, especially the newest officer to the team. In order to alleviate her anxiety, she was asked a question that

was felt would make her comfortable: '*How do you feel coming on to your new role?*' She replied that she felt overwhelmed because there were so many elements to the job.

During the interview, the participants were quick to answer questions – agreeing or disagreeing amongst themselves in some cases. They were mostly in agreement with one another. One governance officer had different views, as he felt that the environment within the Governance Department was confrontational and tense. Some of the participants agreed with his views. A flip chart was used to summarise the main points and round up the session.

On checking the quality of the recording after the session, there were buzzing sounds in the background of two recorders, which might have originated from interference of the recorders, due to their close proximity to one another. Thankfully, a SONY Digital Dictation Machine was clear and this was later used to transcribe. The equipment was packed away and I settled down to add a few more notes on observations before leaving (Appendix 12).

3.11 Data transcription

After the interviews and the focus group had been held, the data were transcribed verbatim using unique code numbers for the names of the governance officers (Appendix 13). For most of the interviews, the tape was played, paused and the data were handwritten in a notebook. The

data were then typed onto a laptop computer. This system seemed more convenient than transcribing directly from the audio cassette to the computer. After transcribing, some governance officers were asked to clarify areas that were not clear. In all cases, the transcripts were member-checked by participants to obtain confirmation on its accuracy.

Member-checking established credibility and provided clarity. It also enabled further elaborations on what the governance officers had said. In addition, member-checking confirmed that the requests that had been made by some of the participants had been done. For instance, during an individual interview, a participant had used a vulgar word and he asked that it should be removed. Another participant, during the member-checking, said that he was comfortable with the comments that he had made re: being in a confrontational environment within the Governance Department. The tapes were then stored securely in a filing cabinet. The sessions yielded 63,354 words of transcript data for the individual interviews and 4,385 words for the focus group.

3.12 Individual interviews and the focus group – in context

The findings for both the individual interviews and the focus group were binded by contextual limits. Due to the time difference, the contexts surrounding the individual interviews and the focus group were different and this probably influenced the responses of the governance officers.

The individual interviews and the focus group sought to answer different research questions. The research questions were amended after the individual interviews to address the issue of accountability. A focus group was conducted to address this in sufficient depth. The different contexts might have impacted on the findings of the study.

When the individual interviews were held, the governance officers had recently been converted to generalist roles from specialist roles. They were still 'finding their feet' and they were not yet fully confident. Their workload was heavy and it was constantly changing. The Trust Board has always been committed to governance issues, however, the structural lines of escalation and scrutiny to ensure accountability had not been sufficiently embraced by all the governance officers. The consultants prioritised patient care and some of them regarded aspects of governance activity as tick-box exercises. This sometimes led to non-engagement with governance officers. Hence, the governance officer role was challenging. At that time, the management style within the Governance Department had a high level of surveillance and lapses in expectation were often met with rebuke. Also, a number of governance officers had left their posts. This left a vacuum, and there was a requirement for cover – which gave additional work to the officers that were left.

The focus group, held three years later, comprised some new governance officers. The context was different, as governance activity had stabilised and workstreams were now well-embedded. The governance officers had

become used to the system and as a result, they were more confident. The commitment of the Trust Board to governance activity remained constant. Governance officers had come to appreciate and embrace this and other areas of support. A participant had reported that they enjoyed the support that the Division provided to ensure that directorates were accountable. Furthermore, there was a perceived change in the leadership style of the healthcare governance managers during this period. Governance officers were not under as much surveillance by their line managers as in the years before.

Table 17: The approach and methods that were used to address the research questions

Research Question	Why is it important?	How did I develop it?	How will I answer it?	Has it been answered?
1. How do governance officers narrate their role?	This research question allows the governance officers to tell their story. Its purpose is to provide an understanding of the role of the governance officer.	I realised that there was no literature on governance officers and, therefore, I decided to research into their role, experiences, challenges, etc.	Via individual interviews and a focus group which will capture governance officers' perceptions.	Yes – eight individual interviews and a focus group have been conducted
2. What is it like to be a governance officer within the UK NHS accountability framework?	My study focuses on the role of the governance officer in ensuring accountability. This research question enables me to explore what it is like to be a governance officer ensuring accountability within the NHS.	The key role of governance officers is ensuring accountability at a local level. It is important to know the views of the governance officers on what this is like.	Via a focus group	Yes
3. How do governance officers describe and experience accountability mechanisms in their local environments?	Accountability mechanisms are the means by which governance officers carry out their responsibilities. The mechanisms ensure that directorates are held accountable for the quality of treatment and care.	The mechanisms involved in ensuring that the directorates are held accountable for the quality of care and treatment given to patients are key to the study.	Via individual interviews and a focus group which will explore governance officers' perceptions on the mechanisms.	Yes
4. How does the pursuit of accountability influence power	The governance officer role pivots between two powerful groups. To develop an understanding of how power	I am interested in looking into how the game of power is played and also the tension that is inherent	Via focus group	Yes

Research Question	Why is it important?	How did I develop it?	How will I answer it?	Has it been answered?
dynamics and tensions within the Trust?	comes into play and how this could lead to tension.	with it.		
5. How does the practical engagement of the governance officers affect their sense of self?	There is no literature on governance officers or their identity. The research question will fill in the existing gap on the identity of governance officers.	To have an idea on who the governance officer is.	The individual interviews and the focus group which will capture governance officers' perceptions on their identity.	Yes

3.13 Data analysis of individual interviews and focus group

3.13.1 Analytical considerations

A variety of methods for analysing the data were considered. These included critical discourse analysis, interpretative phenomenological analysis (IPA), narrative analysis, silences framework, thematic analysis and thematic narrative analysis. Following extensive reading about analytical methods and detailed consideration with regard applicability, the thematic analysis method was chosen. The next section discusses thematic analysis, including the reasons why this was chosen as the analytical method.

3.13.2 Thematic analysis

Thematic analysis is a flexible and valuable approach to analysing qualitative data. It reveals patterns of meaning and it provides a rich and detailed account. It is especially useful in research such as this, where there have been no previous studies. Braun and Clarke's six-stage approach to thematic analysis (Braun and Clarke, 2006) is a systematic and rigorous method of analysing data for patterns by developing codes and themes (See Table 18).

Table 18: Six stages of data analysis and their description (Braun and Clarke, 2006)

Phase	Description
Phase 1: Familiarising myself with the data	Transcribing data, reading and re-reading the data and noting down ideas.
Phase 2: Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire dataset.
Phase 3: Searching for themes	Collating codes into potential themes, gathering all data relevant to the potential theme.
Phase 4: Reviewing themes	Checking the themes to see if it works in relation to the coded extracts, and producing a thematic 'map' of the analysis.
Phase 5: Defining and naming themes	Refining the themes and generating clear definitions and names for each theme.
Phase 6: Producing the report	Extracting examples, analysing selected extracts, relating back to the research questions and literature to produce a report.

Thematic analysis using Braun and Clarke's method (2006) was chosen because I was interested in identifying and creatively constructing the main themes of the data provided by the governance officers in relation to my research questions. As thematic analysis can be modified for use, it is a readily available method. In addition, it provides detailed accounts of data, highlighting similarities and differences.

Thematic analysis of the data comprised two phases.

Phase 1 – Thematic analysis of the individual interviews undertaken with eight governance officers.

Phase 2 – Thematic analysis following the focus group with five governance officers.

The descriptions of the methods of analysis for both phases are combined because the processes were similar. The focus was on how the participants at the individual interviews and the focus group provided insights of how they ensured accountability. Attention was also on power dynamics, the governance officers' identity and team relationships.

Step 1: Familiarisation with the data

Transcribing the data manually was an initial step towards ensuring familiarisation. Familiarity was enhanced as the hand-written manuscript was being transferred onto the computer. The transcript was checked against the narration on the tape recorder by listening to the tape again in order to ensure accuracy. A few words and clauses that had been missed out were added and typographical errors were corrected. Some areas were not clear in the transcript and the participants were asked for clarification of the issues. This member-checking process also provided an opportunity for the participants to confirm the accuracy of their transcripts and for them to provide final consent regarding the use of some of their responses as quotations (Flick, 2018).

In order to fully familiarise myself with the data, the recording was listened to once more. While transcribing, I tried to identify data that would enable me to answer the research questions of the study. My initial thoughts from listening to the tape and reading the scripts were that governance officers were in a pivotal role – between the managers and the clinicians. Their role was evolving and it involved undertaking a

variety of tasks to ensure accountability at a local level. I was also interested in the areas of convergence and divergence in the data.

Transcribing involved identifying all utterances, including those that were non-lexical such as the 'ers' and 'erms'. Coughs, pauses and laughter were also highlighted in brackets in the transcript. These related to the speech style of the participants and their personalities, and were seen as complementary to the verbal communication. The essence of reporting the non-verbal communication was to recapture the mood of the interview as much as possible. It also provided a thicker description. It was important to punctuate the transcript appropriately so as not to distort the meaning of what was being said. I left the quotations untouched, even where the grammar was incorrect. In addition, where the participants repeated phrases, this has been transcribed as such. It enabled the intended emphasis to be maintained. I struggled with observing body language while concentrating on what was being said during the interviews. Contrary to what some academic colleagues and other researchers have said, transcribing the data was not so frustrating or time-consuming (Silverman, 2016).

Step 2: Generating initial codes

A small sample size was advantageous for the research study because it enabled me to be immersed and empathise with each of the participants while collecting and interpreting the data. Computer software, e.g., NUDIT4 or NVivo were considered, but it was easier to adopt a manual

approach. I also felt that researchers who use a manual approach facilitated an in-depth immersion in the data. Furthermore, there is possible conflict involved in having a highly cognitive process converted into a technical process (Polit and Beck, 2018).

For the individual interviews, once the transcripts had been read several times and I was familiar with the data, an initial coding exercise was carefully carried out. In accordance with Braun and Clarke's guidelines, notes that identified interesting features of the data were made beside each of the participants' responses on the transcripts such that each data item had some jottings. A particular code was then allocated to sentences with similar meanings and some initial thoughts were written to explain the reason(s) for that code. Once a code had been identified, the sentences were marked by underlining them with a highlighter.

For the focus group analysis, similar data items were collated together electronically by cutting and pasting them using an Excel spreadsheet on my laptop computer**.** This was done electronically to save on the time involved with the cutting up of the data extracts and then physically grouping them together.

Step 3: Searching for themes

The third step of the analysis involved sorting the codes that were earlier identified into potential themes. For the individual interviews, the search for themes involved writing the initial codes on 'Post-it' notes, grouping

those with common analogies and sticking them in groups on a large piece of cardboard under a common name.

Themes, such as *Pleasures and Pains,* were identified. Under this theme, there were two subthemes: one theme was titled, *the pleasures of being a governance officer* and the other theme was titled, *the pains of being a governance officer*. The codes under the former theme included: *interesting, because everyday is different; priviledge to be working with hardworking and knowledgeable clinicians; it feels good to make a difference*. Codes under the latter theme included: *some clinicians see governance activities as box-ticking exercises; inadequate training; could be stressful at times* (Braun and Clarke, 2006; 2013). Appendix 14 shows an example of a theme with the subthemes, data extracts and codes that were applied.

For the focus group, all the codes were listed in a column of the spreadsheet. I pondered over each code individually and then identified and jotted down, in the next column, a theme that it was felt that particular code should fall under. These themes were 'data-driven', as they depended on the data that had been provided (Braun and Clarke, 2006; 2013). Once all the codes had been allocated a theme on the table, they were sorted, using the SORT feature on my laptop computer. Appendix 15 shows an example of a theme and subthemes from data for the focus group.

Step 4: Reviewing the themes

The themes were reviewed and refined to ensure that the data were appropriate for each of the theme headings. The task of refining the data was divided into two. The first stage involved reviewing the spreadsheet to ensure that each of the coded data extracts was in the correct location, i.e., checking that each extract had a coherent pattern with other coded extracts. The coded extracts that did not conform to the theme were removed and realigned with a suitable theme or they were placed at the bottom of the spreadsheet – to be addressed under 'Miscellaneous'. This task was time-consuming, but worthwhile, as a number of extracts had unconsciously been placed in themes where they did not belong.

The second stage involved comparing each of the newly-generated themes to the entire data, i.e., all the data that were collected during the individual interviews and the focus group to ensure that they fit. The transcript was revisited and each of the themes was considered to ensure that they fitted in with the data. Following this, the themes were checked to see if any data had been missed. The omissions were added and once the themes were in place, a preliminary thematic map was drawn based on the themes that had been generated.

Drawing the thematic map enabled me to consider the relationships between the codes and the themes and also the different levels of themes, i.e., the main themes and the subthemes. The aim of the map

was to accurately represent the themes. This related to the research questions that were being asked.

Step 5: Defining and naming the themes

For the fifth step, the themes and the thematic map were reviewed several times in order to arrive at the final themes that would be presented for analysis and also to produce the final thematic map. These themes were identified by re-reading the transcript, concentrating and pondering over it for a period of time. During this period, modifications were made to the codes and themes on the Excel spreadsheet and I drew numerous thematic maps in order to arrive at a suitable illustration of the themes and their associations.

The next stage involved refining the themes and my analytical, judgmental, creative and imagination skills were employed in order to identify and describe what the essence of each theme actually was. In order to do this, the data extract was reviewed and I sought to make meaning out of each theme. This took about two days of careful concentration. By this time, my understanding of the themes had satisfactorily developed into logical patterns, including their division into subthemes and their relationships with one another.

The overarching theme arising from the focus group was how governance officers perceive their role of ensuring accountability at a local level. There are various ways in which the data could have been analysed to identify the themes. The approach for this study was mainly influenced

by the research questions and my interpretation of the data using a social constructionist approach. Themes were constantly refined by renaming them and merging some of those that were felt to be overlapping.

To enhance veracity, credibility and rigour of the analysis, peer verification of the themes was done by my supervisors. The supervisors felt that the titles of the themes did not illustrate their meaning sufficiently and they suggested that some themes should be renamed. A few alterations were made after an agreement had been reached.

Tables 19 and 20 show the themes and subthemes for the individual interviews and the focus group.

Table 19: Themes and subthemes for the individual interviews

Themes	Subthemes
Theme 1: The governance officer role	*Subtheme 1:* The governance officer role – diverse tasks
	Subtheme 2: The evolving role of the governance officer
	Subtheme 3: Negotiating with all groups
	Subtheme 4: Suggestions for enhancing the governance officer role
Theme 2: Pleasures and Pains	*Subtheme 1:* The pleasures of being a governance officer
	Subtheme 2: The pain of being a governance officer
	Subtheme 3: Being appreciated (or not)
Theme 3: Unity despite diversity	*Subtheme 1:* Relationships between governance officers
	Subtheme 2: Relationships between governance officers and governance managers/team leaders
	Subtheme 3: Relationships between governance officers and clinicians

Table 20: Themes and subthemes for the focus group

Themes	Subthemes	Key messages from the flip chart
Theme 1: In pursuit of accountability	*Subtheme 1:* Accountability – a shared understanding	Ownership/provision of assurance/Identify gaps and forge better outcomes
	Subtheme 2: The changing world of the governance officer	Shift in accountability over the years
	Subtheme 3: Enablers and barriers to accountability	Performance reviews/Scrutiny/Divisional support *How to improve:* No chasing!/Centralised database/ Ownership/Uniform level of ownership/Designated persons out in the directorate *Not everyone feels that directorates are held accountable. *Some governance officers do not feel accountable
Theme 2: The dual role of the governance officer: policing and nurturing	*Subtheme 1:* Policing – ensuring accountability from a professional distance	No chasing!
	Subtheme 2: Nurturing – advising, caring and supporting	Assisting/supporting
Theme 3: Perception of self and others	*Subtheme 1:* Positive identity	Proud to challenge when confident
	Subtheme 2: Negative identity	
Theme 4: Complex connections	*Subtheme 1*: Relationships	Power/tension: Nurses -> Medics
	Subtheme 2: Power dynamics	Power
	Subtheme 3: Tension relating to structures, processes and groups	Tension

The coding was done inductively, i.e., the identification of the codes was not based on information derived from the literature articles that had been read earlier. The data were also interpreted using the semantic approach, i.e., the surface meaning only of what was said was analysed without looking beyond it (Braun and Clark, 2006; 2013).

Step 6: Producing the report

The essence of the focus group was to explore how governance officers ensure accountability at a local level. In this final phase, the findings which were an account of the story that the data were telling, are presented. Beginning with the first category, a write-up which highlighted the main characteristics of each category was constructed. These findings were supported with examples of raw data that had earlier been placed under that heading until the analysis was completed. Data extracts were used as illustrative quotes to support the story which is related to the research question. Four themes were generated: *in pursuit of accountability; the dual role of the governance officer – policing and nurturing; perception of self and others; complex connections.* The key messages that were collected on a flip chart at the end of the focus group session are also included in the table. The information on the flip chart was a summary of discussions that had been held during the session.

3.14 Data management

The tape recordings for the individual interviews and the focus group were transcribed verbatim using unique code numbers to conceal the identity of each of the participants. The code numbers were provided based on the order of attendance for the individual interviews, e.g., Governance Officer 1 (GO1), Governance Officer 2 (GO2), etc. Governance officers who did not participate in the individual interviews were allocated subsequent code numbers based on their seating positions during the focus group.

Transferability, the extent to which a study is applicable to theory, practice and future studies also needs to be considered (Bryman, 2016). The quality of the data that have been collected should be such that if the study is undertaken by another researcher, similar findings will be obtained. Being a qualitative study with in-depth data collection and analysis of a small localised sample size, the research study is not generalisable (Polit and Beck, 2018). However, if the study is of good quality, the findings could be useful beyond the sample that is being studied (Parahoo, 2014). Future researchers will be able to identify similarities of this project with another project in a similar context. Within the NHS, however, Trusts are different and in proposing change, factors, such as the nature of the change that is being proposed and local politics should be taken into consideration (Fulop, 2012).

Thick description of the research process and the findings were used to put the research study into context with the data that were collected from the governance officers. This enhanced the credibility and transferability of the research study (Geertz, 2000; Polit and Beck, 2018). It would also enable other researchers to make an appropriate judgement about the similarities of this study with other studies. The schedule ensured consistency and also enhanced credibility and transferability.

Reliability or dependability, the measure of the consistency of a study, relates to the potential for replicating the study under similar conditions. It is based on the acknowledgement that the whole research process, i.e., from data collection, analysis and results, is consistent and reliable (Swanson and Holton, 2005; Parahoo, 2014). The quality of recording and presenting data is also important in ensuring reliability (Flick, 2018).

Transparency was ensured, not only as a result of the thick description of data collection and analysis, but also by presenting the data in a variety of ways: figures, tables and quotations, to make it possible for the study to be well-understood and comparable to others. Another method of enhancing credibility was via reflection and reflexivity. This was done throughout the PhD journey. The use of a schedule enhanced the reliability of the study. In addition, adopting the well-established thematic analytic method which was developed by Braun and Clarke (2006) enhanced credibility.

Confirmability is another method of ensuring a research study is of good quality. It is the extent to which the findings of a study are as a result of the views and experiences of participants and the situation around the study. Confirmability entailed my acknowledging the subjective nature of the study, but adhering to it while trying to be objective. In this regard, I ensured that personal values and theoretical inclinations do not influence the findings of the study (Bryman, 2016). In order to ensure confirmability, data were checked a number of times. Checks were done by the participants, and a peer review was carried out. There was also clear indication throughout the thesis of perceptions of the participants. A robust referencing system and the identification of adopted methods also enhanced confirmability.

3.15 Budget and resources

The research course is self–funded and all fees have been disbursed to the university. No funding, in the form of grants or sponsorship, was received for the course. Apart from tuition fees, other costs incurred for the study included printing and photocopying costs, fuel costs and parking fees.

3.16 Summary of the chapter

This chapter has sought to describe the methodology of the research study. The setting for the study and my positionality have been discussed. The research process and design and the instruments that

were used, i.e., the individual interviews and the focus group, have also been discussed. The chapter has provided some context to the environments in which the governance officers that participated in the individual interviews and the focus group took place.

Braun and Clarke's (2006) 6-stage approach to data analysis has been discussed. Ethical issues surrounding the thesis were also discussed. The data that were collected from the individual interviews and the focus group reflected the participants' perception of their experiences, challenges and identities. These relate to how they ensure accountability at the local level. The data are the basis for the findings of the study which are discussed in the next chapter.

Chapter Four

Findings – Individual Interviews

4.1 Introduction

The previous chapter discussed the methodology and the use of individual semi-structured interviews and a focus group to address the research questions. The purpose of this chapter is to present the findings from these individual interviews that were undertaken with eight participants. The interviews attempted to answer the research questions below:

Research Question 1: How do clinical governance officers narrate their role?

Research Question 2: What is it like to be a clinical governance officer within the UK NHS accountability framework?

Research Question 3: How do clinical governance officers describe and experience accountability mechanisms in their local environments?

Research Question 4: How does the practical engagement of the clinical governance officer affect their sense of self?

Research Question 5: How do power dynamics influence accountability within the NHS?

Research Question 6: How can the role of governance officers be conceptualised in terms of a discrete Community of Practice within the wider landscape of NHS practice and accountability?

4.2 Themes and subthemes identified following data analysis

The themes and subthemes were identified using the methods of Braun and Clarke (2006; 2013), as shown in summary form in Figure 6.

Figure 6: Themes and subthemes developed from individual interviews

The findings of the individual interviews are presented below. They are supported by illustrative quotes.

4.2.1 Theme 1: The governance officer role

This first theme represents the participants' views on their role as governance officers. It incorporates the variety of workstreams that governance officers are involved in. The four subthemes that were identified from this theme are:

- The governance officer role - diverse tasks
- The evolving role of the governance officer role
- Negotiating with all groups
- Suggestions for enhancing the governance officer role.

4.2.1.1 Theme 1 – subtheme 1: The governance officer role – diverse tasks

This subtheme highlighted that the role of the governance officers involves a diversity of tasks. The general consensus of the participants was that their workload was varied, and they could not address issues in depth. GO3 explained that the diversity was because there was a requirement for further assurance due to increased scrutiny by the Trust Board on local performance.

> *There is increased scrutiny from Board level down and all of the various committees. They want to drill down into various aspects of work in the hospital and the way they do that is via the GO [governance officer]. We are either auditing something or we need the directorate to give us more assurance. That's our job and it's always been our job. Quite rightly, really, 'cos Trust Board and Division Management need to know we are safe and they need to know things are being done the right way. They've got to know that.* – GO3.

He perceived that the Trust management needed to ensure patient safety. The specific tasks that are undertaken by the governance officers were discussed by the participants.

> *Risk Management, Risk Assessments and all the others. All the other aspects of governance: pillars of governance. Risk Management, Audit, Health and Safety and all the rest – all the workstreams.* – GO2.

> *Erm…, so we've got the prospective audits, which cover DNAR [Do Not Attempt Resuscitation], Falls, erm, Consent, Transfer, ViEWS, [The Vital Early Warning Signs] … erm, Manual Handling [Patient Manual Handling]. So, we monitor those with prospective audits*. – GO3.

> *I remind them to do anything governance-related, such as Duty of Candour, their Serious Untoward Incident Actions, erm, their Audits, how they are doing with the Clinical Audits. Erm…and anything else that gets thrown at us to do – governance-related.* – GO7.

> *Then, you've got all your SUI [Serious Untoward Incident] actions, you check that. Then, you've got any NICE [National Institute for Health and Care Excellence] guidelines that are outdated or that you are chasing. Erm, initial proformas or baselines, erm... You make all those updates on the system, Health Assure. Then, you're updating QRV [Quality Review Visit] Visits. There are actions for those. Erm…or you are chasing people for those.* – GO8.

Participants discussed how they attended meetings with the managers and the clinicians. GO8 also described some of the meetings that governance officers attend and the tasks that take place before and after the meetings.

> *Then, you've got the meetings with your audit leads; meetings with your audit convenors; meetings with your governance leads before the governance meetings; doing all the IGRs [Integrated Governance Reports], erm…, and ensuring any papers have been sent off for the meetings and anything else that needs to be discussed has got to the appropriate people, erm…, going to [smirky, soft laugh] meetings and erm…, then after the meetings, obviously, feeding back and going through any feedback that*

you've got. And then, after the meetings, you've got all the actions that the directorate have asked you to follow-up or anything that you've got to do. Oh! [sigh] What else is there? – GO8.

Meetings are described in more detail in Section 4.2.1.3. Some of the participants felt that the workload was excessive.

With great difficulty – it is a constant juggling act. – GO2.

We have got work up to our eyeballs and we are stressed out. – GO3.

At the moment: 'Yes' – very busy. – GO4.

Some discussed the work pressures in more detail, including the different strategies that they employ to address this.

I think it can be easy to get yourself lost. No, not lost…It can be easy to fall behind, if you are not careful. If you do not plan effectively…if you do not plan like the military [laugh], erm, you will lose it and people will suffer because of that. I think you have to be extremely clever in forward-planning, making sure everything is covered and letting…not letting each of your directorates down. But because of what we have to cover, the details and so many topics we have to cover, it cannot, but be quite challenging. – GO2.

The phone will go and then suddenly you are dealing with some other query and then you're bouncing about databases and whatever, and then somebody in the office might just come and ask you a question, and then you are dealing with that query. Erm, and then you might be bouncing about databases for that. So, how many things am I working on at any one moment? – GO4.

…But then, it is a question of erm, prioritising. And that's the expectation – to prioritise, but it is difficult. Very difficult in this role, to actually, erm, be a governance officer, I would say. I think, initially, I mean, about a year ago, I would say, 'There was no problem'. – GO6.

Some participants felt that some tasks were outside their remit.

It's…We are asked to cover all these workstreams. I think we are all like 'Jack of all trades'. If you know what I mean… including being involved in things that are really not our area of expertise, e.g., Health and Safety, Fire risk assessments. – GO1.

A participant reported that the healthcare governance managers had set up trackers in order to manage these diverse tasks. Trackers are electronic platforms, usually Excel spreadsheets, on which progress on activities over a period of time is highlighted. They provide real-time information on progress made. These trackers showed, at a glance, which tasks had or had not been done by the governance officers.

> *Well, until relatively recently, we had various trackers. I mean, we still have one or two trackers, but certainly 2012/13 was the Age of Trackers for us. There were trackers for this and trackers for that [phone rings]. Excuse me! Tracker... If you didn't record something in the tracker, it would be taken that you didn't actually do the task, which isn't necessarily true, but you know, you then get in trouble for not filling the tracker as well as potentially not doing the task. So, that was one way of monitoring what we were doing.* – GO4.

4.2.1.2 Theme 1 – subtheme 2: The evolving role of the governance officer

The participants reported that the role of the governance officer was always changing.

> *Erm, now the roles have changed, because the last couple of years, there have been massive changes.… The actual role is still under review. I feel it is still under review. I do not think we have anything set in stone… when we have a review on what we do; we always tend to end.*– GO2.

> *It is not the job that I was doing when I first started in 2012; was not the job I was doing in 2013 – things have changed; is not the job I was doing in 2014 – things changed, and in 2015, [last year], even as, you know, things have changed again, you know. We've been just recently asked to give our comments on changes to our role. So, you know, for me, the job keeps changing.* – GO4.

Most of the participants felt that the role of the governance officers was not just evolving, their tasks were also increasing.

…what the GO role actually is just keeps changing, and we tend to keep gaining areas rather than streamlining. That is my personal opinion. Hence, Duty of Candour, SUI actions, all these changes, you know, it's extra stuff and when we have a review on what we do, we always tend to end up with more work than what we initially signed up for, so as a role, it is constantly changing – you can never say your role is this. – GO2.

We get more and more things they need to see; more detail on a monthly basis. You know, a new spreadsheet gets out. A new database or there is something else we've got to add to Health Assure. And that's not going to change, but it's just increased a lot over the last couple of years. – GO3.

The governance managers and the team leaders put more work on us. Because you can see! You can see...! OK. OK. For example, on the IGR report, there is something called IG [information governance] incidents. That's something new, isn't it? Information governance incidents… So now, that wasn't there before! Now, we have this additional work to do. We have to monitor it to its conclusion. That's some more work. – GO6.

…one of them said to me this morning that, erm, they wanted to ...Well, basically, that we were getting more work and they felt sorry for us. They are not governance officers; they are something completely different…
The job evolves and you get more and more additional work to do. OK, they put this, erm, governance role together, but it's, erm, it doesn't stay static, does it? Each month or the next few months, you think 'OK, I was doing that, but now, I've got an additional workstream to do'. – GO6.

For GO3 and GO5, the increasing number of tasks made the role of the governance officer more difficult.

The workload has increased. We don't get any more time to do stuff in and we are very much held to account on timescales and deadlines. So, we've all found, I think. We've all found it a lot tougher in the last couple of years – in the way our roles have gradually developed and the work is increasing. – GO3.

…what I am finding in my current role is that they keep putting more and more and more deadlines and more and more tasks onto us. They do not take anything from your every day jobs, so you've

got to put in the extra input to get, erm, you know, a good standard of output. – GO5.

In the same vein, GO3 mentioned that the department was trying to streamline tasks.

> *…how the department expects us to collect data and how to analyse it and how to record it. That's changed and it's ever-changing 'cos we're finding better ways of doing stuff or we are trying to do more things, but not add to the workload too much. So, we have to keep trying to streamline what we do and improve.* – GO3.

GO1 reflected that at the beginning, the situation was uneasy. He attributed this to lack of experience of the governance officers and their being new on their jobs.

> *It was like, erm…, walking into the deep end with no experience. It was difficult when I first started.* – GO1.

> *Lack of understanding of the role, new managers, new team leaders, everyone was new to the job, new staff were coming in from outside…*– GO1.

Some participants said that there was much to learn within a short pace of time and there was a lot of work to be done.

> *...they decided to change our roles to a general role and of course, with that in mind, we had to learn very fast. So, erm, we had to learn a lot of workstreams which includes, erm…, Prospective Audits, doing Clinical Audits, NICE Guidance, which I didn't know anything about, erm, Risk Register – I didn't know anything about, Incident-reporting, SUI Actions, erm, Duty of Candour, which we had to recently learn, erm, External Reviews, Patient Information, Information Governance, Losses and Compensation, etc.* – GO6.

GO6 pointed to her own attempt to become familiar with procedures. She also stressed the role of tacit knowledge and learning by doing.

> *Well, apart from the fact that they gave us a lot of, erm, training, I tried to, erm, read around as well – by reading the policy, OP10 [Operational Policy 10 – Risk Management Reporting and Patient Safety Policy]. I tried to do that…and a lot of it is just hands-on experience. You are just learning as you are going along. I think*

that we are still doing it, erm, now. Three or four years later, we are still doing it now, because the job is evolving. – GO6

GO1 did see improvement over time.

The role of a GO when I first started was not as good, but it's better over the years. – GO1.

4.2.1.3 Theme 1 – subtheme 3: Negotiating with all groups

The formal system within which governance officers work is bureaucratic with deadlines for the completion of tasks, as noted in Chapter 1. The participants talked about ways in which governance officers negotiated with other staff groups in a bid to ensure that governance requirements and targets are met in a timely manner. There are, however, also informal systems that governance officers are involved in, in order to ensure smooth operations. A variety of meetings were held, some were formal, while others were informal.

GO3 said that he preferred attending some meetings to others.

…we all have to go out to our directorate governance meetings every [without exception] every month. So, we've all got four or five meetings per month, don't we? At least, there are a couple of ones that I enjoy more than others because of the personnel and because of the rapport that I've built up with people in the directorate. – GO3.

However, GO4 felt that attending meetings took away from him, the time that he would rather use for office work.

I don't have a problem going to meetings, but I hate having a day where I've got two or more meetings. Erm, two meetings, I can kind of cope with, but it irritates me 'cause then I feel that I haven't been in the office all day. – GO4.

GO1 said that, initially, he had felt uneasy attending meetings with people he was not used to. He explained how he used tact, diplomacy and persuasion to establish position with limited knowledge and authority.

> *Going to meetings with, erm, strangers. If you like, meeting strangers whom you have never worked with before, never seen. They are asking questions that you do not have an idea how to answer.* – GO1.

> *Well, when I pass those messages, I tell them it is not from me, not from Governance. It is from Trust Board, it's from external organisations. It is the law. It is Trust policy and we have to do these things.* – GO1.

> *You have to…I think you have to be persuasive and erm, erm, What's the word? Let them realise it is important. It is not a waste of time. It is for their benefit. I have to be diplomatic when I tell them about such issues.* – GO1.

GO3 talked of negotiating effectively with the clinicians by being helpful and respectful.

> *It is in the way we couch things to them [clinicians], it's in our approach and it's what we say. 'We need you to do this, but I can help you do it. You know, I need you to give me this information, but I can type it up for you. I can take it away to Division'. You know, if you put things in the right way, if you negotiate and be respectful to them, I think you could win around even a very, very busy and stressed-out consultant.* – GO3.

GO4 talked about the support system within the team, which involved the wider governance team. He also appreciated the support from team leaders and the governance managers.

> *But at least, I suppose, one of the things we have, in the governance office is a system where the managers, in a sense, are supporting us. Like… So, we have team leaders who are like the next layer along, and then there is an assistant healthcare governance manager and then there's two healthcare governance managers and beyond that there are people in the governance*

team [governance family] who give us support and backup. I should have mentioned that earlier as one of the positives of the role. The things that help you with the obstacles and help you with the challenges is this support network that we have. – GO4.

Another way of monitoring is via 1-to-1s that we have with our line managers. We also have 1-to-1s with the supervisors and that's another way of monitoring what we are up to. Erm, there are various deadlines that the supervisors and the managers have to meet and our work feeds into what they do. – GO4.

Some participants acknowledged that governance officers worked differently because of both differences in their personalities and also those of the clinicians.

Because there's that many personalities, different types of people and you've got to…it's not like you've got just one directorate…but they are huge areas and it is having that personality to try and get on with everybody. – GO2.

GO3 said,

I can't really say what's right or wrong 'cos you know, we've all got our different styles and you only know whether it's been successful or not.

4.2.1.4 Theme 1 – subtheme 4: Suggestions for enhancing the governance officer role

The participants suggested ways of enhancing the role of the governance officer. GO2 thought that governance officers should work more directly with the directorates by being physically located within the directorates. She, however, felt some tension between the governance officers working as a team and their need to work within the various directorates.

It could be improved if you had a governance officer per directorate. I really do think and having that time to sit with your directorates and move things forward. The only problem you've got

with that is you could become isolated and don't learn anything from anybody else. – GO2.

GO1 felt that the governance officer role should be streamlined to avoid workstreams where there are dedicated staff already employed to address them. In a similar vein, GO8 felt that managers should communicate new policies and other changes directly to the directorates.

I do not think we should be involved in these [Health and Safety and Fire risk assessments], if they already have dedicated staff who are experts in that area who can advise clinicians or staff on these areas. – GO1.

Erm, like we're the ones making the rules and sometimes I don't know whether we are the right people to set out the expectations, erm, because it is not seen…I don't mean that we are seen in a low position, but we are not managers and sometimes. I do feel like managerial input, erm, might help more than when there is only an issue and you escalate it. I think, sometimes, it could be done before then. So, when there's new policies or changes or something like that, I think, sometimes, it would be easier for it to come from a manager rather than us. – GO8.

The issue of recruiting the appropriate staff was seen as paramount.

I think most staff have varying ability. I'm not trying to be mean to anybody, but I think to pick an interview with some careful questions and maybe a test of some kind, where the people are really optimistic, 'cos the job is challenging. It is not for everybody. – GO3.

Suggestions for enhancing the governance officer role were made by GO2 and GO3. GO2 felt that the role of the governance officers could be more efficient if their workload was reduced. She proposed that some tasks should also be done by clinicians.

To be more effective and to ensure that we are given enough time to do a job, we may need to cut down on what we are actually doing

and take out some of the tasks that could easily be done by the directorates themselves ... – GO2.

For GO3, the role could be enhanced if the governance officers took ownership. GO3 felt that if the governance officers were more confident, more organised and more disciplined, the role would improve.

I think we need to be…act a little bit more… [I don't know] with a bit more autonomy and we don't necessarily have to pass everything down to our managers. I think we've got the ability to stand up to consultants and with group managers and say, 'Look, this is what the Trust needs. This is why the Trust needs it and we need it by next week because it is needed to go to this meeting or another'. And I think if we could all step up a little bit in that way and be a little bit more confident in our own ability. – GO3.

Good timing is important and diary management – as our bosses keep banging on to us. They are quite right. If you can be organised and self-disciplined and if something in your diary said it needs to be done today, don't just move it to tomorrow at the end of the day. – GO*3.*

4.2.2 Theme 2: The pleasures and pains of being a governance officer

This second theme that emerged from the data focused on the positive and negative experiences of the participants as they carried out their roles. This theme has been divided into three subthemes, as illustrated in Figure 6 at the start of the chapter.

4.2.2.1 Theme 2 – subtheme 1: The pleasures of being a governance officer

During the interviews, some participants talked about the positive aspects of being a governance officer. They said that the role was

interesting and they had a sense of fulfilment when they realised the positive impact that their role was having on patient safety.

> *It could be interesting, and most of the time, it is interesting.* – GO3.

> *…making a difference if you can. What you've done has made a difference… it gives you self-confidence [a boost]. You think it is worth coming in everyday? Probably, if you get nothing back, you are constantly being down-trodden [laugh], then you think 'well, what's the point?' You need that boost, er… that encouragement and to see the results of what you are actually doing, I think that's... that's helpful. And I have seen it in bits and I think that is what keeps you going as a governance officer*. – GO6.

Apart from being satisfied that they were making an impact with patient treatment, governance officers felt satisfied if some other members of staff appreciated their input. GO3, for example, said:

> *You know that's fulfilling when somebody kind of understands our role and its value, 'cos there are still some, perhaps old school consultants out there, that don't really see the value in us.* – GO3.

> *I think we've got better and the Trust acknowledges we are in a better position because of the information we pull together and it's hard for us sometimes, but judging from what gets fed back from the managers, I think the Trust is pleased with us.* – GO3.

Some participants explained that the variety of the activities that they undertake also enhanced their satisfaction with the job.

> *Erm…, in terms of what I like…I like to see progress, because, erm, you can see like, for example, you can see some of the audits that they do – the progress that they are making with the patients. Erm, so I don't mind doing, like the, erm, audits with them.* – GO6.

> *I like how varied the job specification is. I'm doing…Like we're doing the same thing over a week or so, but it's always doing something different and you're always asked to do something else, which is*

totally different as well, which is nice. It is nice because it changes up the pace, changes up the routine. – GO7.

While some governance officers felt that the diverse nature of the role was challenging, GO8 saw a positive element here.

Erm, to be honest, I quite like the bit that's not actually meant to be part of our job [laugh]. Like looking at the reports of any of the audits and completing the database, saying whether they were compliant or what actions they could take, maybe, to improve compliance next time. – GO8.

For GO4, satisfaction came from working with those he called 'hardworking' clinicians with 'positive' attitudes, while GO7 remarked that his satisfaction was derived from relating with clinicians who were in senior positions.

…every day I have the privilege, if you like, of working alongside some really, erm, hardworking and really positive and knowledgeable clinical people. Erm, and I know that's not an experience per se. But for me, on a daily basis, that gives me a lot of cheer and a lot of hope. – GO4.

The main reason I think it is, is because we are involved with the main people, with the people in the directorate that are in the highest position in that directorate – so we get to hear a lot of things that we shouldn't hear or we wouldn't hear. So, it is interesting in that sense. – GO7.

Another participant explained that the variety of tasks she was undertaking made her feel good, as she felt that she was constantly acquiring knowledge.

So, you constantly evolve – you are constantly learning as a GO. And I think it is good as well, because you don't want to become complacent. – GO2.

GO3 talked about how pleased he was to realise the expected outcomes and also receive long-awaited feedback from directorates.

> *… if you all work together and reach the same outcome and it helps them to complete a project, an audit project or whether you are able to thrash out a particular risk and get it on to the risk register, and everyone's satisfied with that outcome, then that's a…, that's a good thing, you know. It's small victories, really, in our job. Erm, I do not know if I'd describe it as joy. Yeah, there are some things that you find pleasing – when you finally get a response from someone that you have been struggling to get a response from. Erm, if there is a particular area that never never engage with us and then they suddenly do – yeah, that's very good when they say something nice about you, like they sometimes say at meetings.* – GO3.

For another governance officer, satisfaction came from organising memorable events such as taking part in the Audit Awards.

> *Audit awards that we were doing now. That, I think, in terms of organising it, er, reading the audits, er, pulling out the best ones, erm, then seeing it presented, delivering it and being part of that. I did...I mean, I do enjoy that! I did enjoy that. Erm, that, for me, was one of the best things from last year, anyway*.

During the individual interview, GO7 described the job as a 'breeze'. He claimed that the bulk of their role was based on the directorates carrying out tasks and notifying the Governance Department once the task had been completed.

> *I realised, 'Wait a minute! None of the work is actually coming down to me, in the sense that the work that I have to ask for, is always the directorates' responsibility to respond. If they don't respond, I don't get an answer. What more can I do?'*
> *So, when I realised that, it's like, 'OK, if they are not going to respond, they are not going to respond. I'll just escalate it upwards'. So, I don't feel that pressure. I know that some governance officers feel like, if their directorates have done poorly, it's a reflection on them. But I don't see it like that and it only took me like two months to get me to that point and since then it's been a breeze, really.* – GO7.

GO7's comment above was put forward as a prompt to other governance officers and to explore consensus or divergence on this view. The perception of the role of the governance officer being a breeze was quickly debunked by two other participants.

> *No! It is not a breeze! Definitely not a breeze! I don't think...No! Absolutely, not a breeze. A breeze means that you just ...you ... everything is 'honky dory' – everything is fine. Everything is nice and gentle. A breeze? No, it's not! It's not a breeze. It's something that you just do with your eyes closed. I don't think that you can do this job with your eyes closed.*
> *You have to think, 'Oh! I'll apply this rule, but then there are other things to consider'. There's nothing straight-forward in the job. It is not plain-sailing – not at all. I don't think it is at all.* – GO6.

> *I don't agree that it's a walk in the park. I want to swap roles with whoever said that [laugh]. Yeah. No, no, I don't find that. I think you have to work hard to get…Maybe, it's just my directorates then. I think you have to work hard to get good results.*
> – GO8.

It was acknowledged, however, that the responsibilities of the governance officers differed from one directorate to another. GO6 agreed that the workload of a governance officer could be a breeze, if the level of support required by a directorate was minimal.

> *It depends on which of the directorates you work for. If you work for the easy ones, it is a breeze, isn't it? It depends on how demanding, how difficult your directorates are. How large they are, if they are, erm, compliant with you. That's when they could say that it's a breeze.* – GO6.

4.2.2.2 Theme 2 – subtheme 2: The pains of being a governance officer

Participants were passionate in their views about the pains of governance officers. Some participants spoke of the challenges that they experienced at the start of their role and the difficulty associated with having a diverse

and evolving role. This relates with Theme 1.2, "The evolving role of the governance officer".

> *The most challenging at this moment in time, erm, is the variety within the job description, I think. We have to concentrate on so many areas that, if you've got four directorates, you got to maintain the same level for each one.* – GO2**.**

Some participants were concerned about tight deadlines and the frustrations associated with these deadlines.

> *Also, when we are given deadlines that we know are unachievable, I think. You know, when you can't really negotiate it with your bosses. It's something that's got to be done and you've got a week to do it or three days to do it. And you know you are going to struggle to really get this information back. You can almost see the problem on the horizon, can't you? Erm, that is a bit frustrating. It's a challenge for us, really to find a better way of working and a better way of doing things.* – GO2.

> *I think more and more now, it has become more difficult because of the competing deadlines and even if you miss a day or two, you've missed so much, erm, it becomes, 'Oh! Shall I really have some time off?' because you're worried in case you miss anything, and that's not a good place to be, I don't think. No!* – GO6.

GO3 felt frustrated that they had inadequate time to support the directorates to bring about quality improvement.

> *Due to the way our work goes [upwards through our managers to Division and to Trust Board, erm, and that is a bit frustrating], we don't find the time to do work that perhaps we'd like to do with the directorates, or they would like us to do. You know, real quality improvement, looking at particular aspects of their work.* – GO3.

Other participants were concerned that governance officers were sometimes made accountable for some of the tasks that lay with clinicians. The governance officers had no control over these tasks and this was said to be frustrating.

…but now the uncomfortable is to do with being made accountable for tasks which we have no control over, requests which we have little or no control over. I am not happy with, erm, being made accountable for tasks which we have to rely on other people. It is a constant battle. – GO1.

It is a constant battle. I think it should be made fair. We should only be made accountable if we have full control over…, if we are fully responsible. Some things, we can be made accountable for, such as writing reports, audit reports, collecting data. I think most… for most tasks, we should not be held accountable. – GO1.

Erm, for example, the audit database…it's a good system, but the people using it… should be using it, aren't using it to the full potential, so it's, er, for us, governance officers, to pick up; like everything else. The risk registers, it's for teams to manage – not for us, but we end up picking them up. You know what I mean? – GO5.

The participants also felt frustrated at the reluctance of clinicians to engage with governance-related issues.

Erm, the frustration comes, I think, when we struggle to get engagement from the clinical side of things. Whether it is due to them being too busy and too stretched to work with us or whether they don't [laugh] particularly get the governance thing. They don't want to engage with us. That is another matter entirely, but erm, it can be quite frustrating at times... – GO3.

GO8 also pointed strongly to the challenge faced by governance officers as a result of the lack of interaction by the clinicians.

Erm, probably, the amount of chasing that you have to do to actually get people to do what they need to do. So, like SUI actions and everything like that. You are just constantly, sometimes, hitting your head against a brickwall. And you know, I'm always saying, 'I'll come and meet you; we'll go through it', but it's… they don't have time. So, yeah, I find it difficult in that way. – GO8.

Some respondents tried to explain what they saw as reasons for the lack of engagement from the consultants.

They do not see governance as their main job. They look after patients. Clinical duty is their priority, so things like clinical

governance meetings, audit meetings, they are not as important. – GO1.

Say, for example, with NICE guidelines, erm, invariably, they are big documents to read and then we send out to the directorates a short document to fill in, in the first instance, but then, a fuller document to fill in in the long term. My frustration comes when you've given them the fuller document and said, 'Look, you have three months to fill this in'. Then about a week or two before the actual deadline, they are saying, 'Oh, I haven't got time, I didn't understand it or whatever. – GO4.

In Chapter 2, we saw how clinicians were described as being averse to clinical governance. GO3 and GO8 felt frustrated with the negative attitude of some clinical directors to governance.

The worst time is…the most frustrating thing is when you come against a brickwall. You know, you need to meet with Consultant A, because he is the clinical director, but he really doesn't like governance – he doesn't get it. He sees it as a bureaucracy and they don't give you anything you need. They get nothing from you and you get nothing from them. – GO3.

I think especially with, erm, clinical directors, they just kind of see it as a box-ticking exercise and it's not their priority, so…and they are very busy. – GO8.

Some participants felt frustrated that in spite of incessant requests for information, some of the clinicians would not engage.

You know, you will send the e-mails out or we will contact people by telephone to ask them to assist us in completing a piece of work, erm, usually, with a 2-week deadline to complete and quite often, you will get no response. So, you have to follow it up with another call or another e-mail. Erm, and some people just will not engage. They won't…either they won't answer you or when they do respond to you, it's a very blunt, 'I haven't got time for this, erm, I don't see the point in giving you this information. I've already done A elsewhere', or 'blah blah blah!' You know, erm, it's difficult, really. – GO3.

Frustrated, erm, that I'm trying to do a job and I need them to give me the information and they don't see it as a priority. Whereas, it

is, because I don't…I'm constantly explaining the hierarchy; that it's not the Governance Department. It's not me personally asking for this information. It goes to the healthcare governance managers, it goes to the Trust Board, to Commissioners - that it's a lot higher than just me asking for something. Erm, but I've explained that so many times – anyway, it doesn't seem to…It just goes over some people's heads. They don't care. – GO8.

GO1 was convinced that the lack of engagement of some of the clinicians was due to a lack of interest.

Well, it is difficult to engage if they have no interest. – GO1.

GO2 expressed dismay that governance officers were criticised if they made the slightest errors.

Well, people have been off and we've been so short-staffed. But you've covered for three people, you've picked up their workload, but you wouldn't necessarily get a 'Thank you' for it, but you'll be told if you haven't put one date on a spreadsheet and sometimes, I could think, 'Hang on a minute! You know that date is in another place that's easy to find. You know, it's either a typo or 'cos there's something in that box. Why make a song and dance, especially after what we done previous?' – and that's what annoys me. – GO2.

Some clinicians did not engage with the participants based on their personalities, position and power. The participants felt disappointed that they were not regarded positively.

I think there are always some meetings where you haven't built the rapport with people or you upset them at some point. Or you know that they've got a certain amount of disregard for what we do. It's not very…I do not believe it's personal, I have to say. I think they've often got a little bit of disregard for what we are asking them to do and they think we are bureaucratic, and all the little crunches or whatever they think we are. You know, when you know already, the meeting is going to be a waste of three hours that they are probably going to be a bit sarcastic with you. You'll probably, end up coming away feeling a little bit dissatisfied and a bit, you know. That's the worst part, I think. – GO3.

There was an informal collective sense of non-engagement of some consultants.

> *Erm, well… yeah, they were…they had blank faces. It is frustrating. One of…one of them fell asleep! [laugh]. One of them fell asleep. Three of them started chatting away. None of them was paying attention. So, I am like, 'Why am I bothering with all this? I should just sit down. Why am I bothering presenting this?'*– GO7.

> *We do get confrontations. We do get disagreements, but it needs to be handled in the right way. And for a... for a very professional high-level person in the organisation to talk to you like a child or like he is at school is ridiculous. You know, that's the worst part of the job. Thankfully, it does not happen very often.* – GO3.

> *Sometimes, it doesn't bother me, erm, but er, cos it's my job, I just get on with it. Erm, but then other times, when I'm in meetings, you kind of feel a bit worn down – a little bit. I guess because they are constantly bashing 'Governance' and you're sitting there as the only member of the Governance Team and [laugh] they are just like, 'Governance wants this and they want this', and the…You are kind of…it does get you down a bit, really [laugh] 'cos you want to stick up for yourself and say why it's important, but then when you are surrounded by a whole room of consultants that don't agree, it's kind of a waste of time.* – GO8.

One participant remarked that the staff viewed governance officers as occupying the lower hierarchy of the Trust.

> *…I know what it is like. You are a [should I swear?] lowly Band 5; a s*** Band 5 in people's mind. People have the perception, 'Oh, he is a **** Band 5. Who the hell does he think he is to come and say what he thinks of?'* – GO5.

GO4, however, reflected that self-esteem was important for a governance officer. He said that no matter what type of situation a governance officer was going through, the focus should always be the patient.

> *So, in as much as it might be uncomfortable that the doctors or nurses or whoever aren't making you feel nice, it's because it's not about you – it's about the patient, you know. So, you need to have a very good sense of who you are. You can't come in to this job*

without a good sense of self-esteem and be able to deal with what comes your way. – GO4.

Interestingly, GO5 emphasised that the governance officer role was easy and simple and in the same breadth, he stated that it was challenging and stressful.

I just think it's, er, it's easy being a governance officer, but in terms of, er, work output, you know, energy consumption, it's hard. It's very, er, it's a very stressful job. – GO5.

Being a GO is easy. But you have to run it like a long marathon. You know, it can really, erm, be very stressful in terms, er, of work/life balance, erm, you know, conflicting deadlines. – GO5.

This same participant, GO5, compared the role of a governance office to being in a hot fire.

It is, er, like being thrown in a deep end in the furnace in the hot fire. That's what it is like.

Some participants felt frustrated with the inefficiency within the system.

It usually works like that; if I don't get a response from one, I go to someone else, and if I don't hear from them, I go to someone else and if I don't hear from them, then I escalate it to my managers, which gets taken to Division. But it's funny that they don't respond to us, but once I take it to someone that is in a higher position to them, and then I get a response from them. – GO7.

One participant was dramatic in his perception of the level of inefficiency in the Governance Department.

*…everything you say and do falls on deaf ears and the blind. Nothing changes. It makes you feel like s*** coming to work. It makes you feel like s*** coming to work. It makes you feel like you want to whack somebody. You know, whack somebody, but you can't do it. That's what it makes you feel like undervalued [you can put in your notes] It makes you feel overworked and undervalued.* – GO5.

Other governance officers complained about the lack of awareness of the role of the governance officer in some directorates.

> *… but he doesn't want somebody in a perceived lower admin. role coming in and telling a high-level consultant that they need to be completing their audit plan on target, you know, and on time. So, that can be a challenge. I use exactly the same approach with other consultants and they have been absolutely fine and happy to work with me*.

GO1 said,

> *They were my enemies when I first started. Disagreeing on everything or most things I tell them to do. Telling me it's not their job; it's my job: one of the very first examples was me taking the Minutes. They asked me to chair governance meetings, take Minutes of governance meetings and do various tasks for them – not on my job description.*

4.2.2.3 Theme 2 – subtheme 3: Being appreciated (or not)

Appreciation took the form of positive feedback at meetings and appraisals. The participants acknowledged that appreciation came in trickles, but it felt good to be appreciated for good performance.

> *Erm, I had…in fact, I only had an appreciation last week, and it was to do with my audit plan: 'You got to pull it together'...we eventually did, and this year, I constantly made sure that didn't happen because I got control from the start. And I actually got thanked for it last week, which was nice to hear and it was the first 'thank you' I've had.* – GO2.

> *The feedback that we get. Very rarely, but when we've had a big inspection like the CQC or NHSLA, we get good feedback, because we are seen as key to providing this assurance.* – GO3.

Many of the participants were glad that they were appreciated by others.

> *You know, it's …you do your job and then it's nice for me to sit in a governance meeting [or not even a governance meeting] and they've said, 'If it wasn't for you, we won't have...Thank you'. And it's the appreciation. But we are not just supplying the information*

just to be pushed to one side, but it's being used, it's…and something good has come of it. – GO2.

It's nice because you don't always think you are doing that good a job. So, it's good to be told now and again. You know, we don't need constant reassurance, but it is nice. – GO3.

In addition to feeling good from being appreciated, some participants felt proud about their jobs.

I've actually just had an annual appraisal which was good. It's job satisfaction when you're being told that you're doing a good job and when you are covering for a colleague – erm, it's good to know that you are doing a good job, if they want you to stay. – GO1.

GO2 said,

I feel proud of what I have achieved. I feel that we do a lot of work and we are not, erm, we are not an appreciated role with it. – GO2.

GO6 felt that the clinicians in the directorates she supported appreciated her because she does a lot of work for them.

Although I do think the directorates that I work for do appreciate me. I can honestly say that. I know that they do appreciate what I do for them, because l try and do a little bit over and above – so that it is reciprocated as well. So, in that respect, I do know I am appreciated. – GO6.

GO2 and GO7 both said that they felt that governance officers were not appreciated enough.

I don't think GOs are appreciated with how much work they have to do. I think if we were pulled out, then people will sit up and realise exactly how much we do. But until that happens, or ever happens, or changes, they rely on us for such a lot, but we are just taken for granted, for want of a better word. If things are not going according to plan, they say, 'Oh, it is Governance'. No, we are not appreciated – I don't think. – GO2.

And it was, 'Can I have this? Can I have that?' And then I went out of my way to do it all and then there's nothing. You don't need their 'Thank you'. [laugh]. – GO2.

> *…it demoralises us (well, me) because, you know, I'm doing all this work and you are just going around saying, 'Oh, you know, push it aside, don't think it's important enough' or what not. And their attitude towards GOs, it is demoralising and I don't think clinicians or any staff…people out there, they don't really get that. They don't really understand your attitude can affect someone else.* – GO7.

4.2.3 Theme 3: Unity despite diversity

The participants were united by a common vision, and this vision appeared to be shared by the rest of the Trust. The participants all commented on the significance of relationships within the Trust, advising that maintaining good relationships was a high priority.

Three subthemes were identified from this theme: relationships between governance officers, relationships between governance officers and governance managers/team leaders and relationships between governance officers and clinicians.

4.2.3.1 Theme 3 – subtheme 1: Relationships between governance officers

The diversity within the team was highlighted by a couple of participants.

> *…completely different personalities. We are kind of like this…I think the department is quite a bizarre mix of characters. Erm, we are all different as you would expect.* – GO3.

> *Bonding...I think we all get on. I think, obviously, sometimes, you have the ups and downs, but I think in terms of the team...because we've had different dynamics*. – GO6.

There was a general consensus among participants that the governance team was a happy and strong team.

For me, the main support is the people I share my office with and, as I said, we are about 14 different people and we have a laugh! You know what I mean? We are laughing and joking all the day long, you know, and not doing our work... We are doing our work as well, but we are enjoying being with each other. We don't have any choice about it. We are with each other for, you know, 40 something hours [roughly-speaking, each week]. So, we need to get on with it. Like I said, sometimes it seems like the directorates are against us, you know - and we have each other, so that kind of helps me on those days. Most days – not just on those days. Most days that helps. – GO4.

But in terms of problems with the team, I don't think there's problems with the team. I think, erm, if anything, I think everybody helps each other if we need help, but I think it is just a pressurised job. I think that's the upshot of it. – GO6.

You spend far too much time at work to be unhappy. I try to have a little bit of a laugh and a joke with my colleagues, if possible. – GO3.

GO8 stated that the team members supported one another whenever it was necessary.

Erm, but I've never had somebody turn around and say, 'No, don't ask me that' or 'come back later'. I've never had that. Erm, they're really supportive, but I think that they do feel some of the same frustrations 'cos we do talk about it quite a lot in the office. – GO8.

…but I don't think if I didn't have the support of the people in the office, erm, that I will probably, still be in the job. Because it's …I found it quite demanding, erm, but it's only because I've such a great…erm, like people around me that I know are going through the same thing. And they are so helpful and erm, and you kind of talk to them and you know, when they are having bad days, you kind of know and it makes you feel, 'OK. It's not just me.' And it's like really supportive environment. That's what kind of has kept me here. – GO8.

Contrary to the above, some of the participants highlighted that relationships were not always cordial. They talked about friction and disaffection amongst some members of the governance team.

There is friction between some areas; not… not GOs. Well, some people within the governance officers' team, but also within other departments, such as compliance. Yeah, there is some friction there. – GO7.

You know, when you talk to people and you hear people talk. Or when you talk to them, it's like there is tension in the atmosphere and they are a bit snappy [laugh]. And it's only towards you or anything governance-related. It's a bit 'iffy', but I think it's just drama. – GO7.

And, there seems to be a lot of sickness in the team as well. Is that stress? Is it that, erm, because people don't like working here? Or is it because if you work here, it makes you ill? I don't know, but I do notice there is a lot of sickness within the team. – GO5.

Another governance officer felt she was not totally accepted into the governance officer team.

Erm, I feel one member of the team feels I shouldn't be where I am all for the, erm, I haven't got the degree but still talks to me pleasantly. Erm, sometimes, sometimes, we come together as a team. It doesn't make me feel bad, because the one person that tends to dig about it, I know I do a lot more than them, anyway [laugh]. I am really well, but sometimes, I feel part of it. But then, other times, when I've needed help, it's not been there.

…but other times, people do pull together and I think, do I feel part of the team? I'm getting there. I think I'm part of the team. I always will be. I've been there a long time. But part of the team as a governance officer, I'm 85% there.

GO6 said that some governance officers were not 'honest' and open and GO2 felt that governance officers did not always work as a team.

...I don't think people are as honest as they should be. Only because they don't want to, erm, get...I feel they are really being cautious. I don't think people are honest enough. But that's because I feel that they are holding back a little bit. – GO6.

At different periods, different people have been off. There's only been three or four and we've had to cover sick leave, erm, you know, maternity leave. … and then all I needed was an hour and a

half to take. 'Well, I'm not… But I couldn't …' You know what I mean? You feel like you put your all in it and get nothing out. – GO2.

GO3 commented that due to the heavy workload of governance officers, they could not always assist one another.

Because when I feel like I'm up to my neck in work and I'm…a little bit, I generally wouldn't accept, well, offer any help to anybody else. And I think we are, generally, all the same. Erm, with one or two exceptions – there are probably, a couple of people that would always help, no matter what – which is lovely.

So, it becomes more difficult and more stressful, you know, when somebody is desperate for help. You, sometimes, just can't find the time to help them do that. Maybe, probably, 'cos you don't want to let them down or you're gonna get yourself in trouble. But there's not one person in there that would never really offer to help you. Sometimes, you have to prod people a little bit and say, 'Come on, I really need a hand here, it's only gonna take you half an hour with your help'.

4.2.3.2 Theme 3 – subtheme 2: Relationships between governance officers and their managers/team leaders

The perceptions of the participants about the relationships between the governance officers and their managers or team leaders were divergent. Many of the participants stated that they received support from the healthcare governance managers and the support leaders.

You try your best and you do have supportive managers. My manager is very very supportive. Erm, I think they've got our backs. I think if there's ever any criticism labelled at us, I think they are very quick to stress to people on the outside how hard we work and what pressures there are on us. I think they are very good at that. Erm, they probably cannot give us the time that each of us would like. – GO3.

So, we have team leaders who are like the next layer along, and then, there is an assistant healthcare governance manager, and then, there's two healthcare governance managers and beyond

that, there are people in the governance team [governance family] who give us support and backup. I should have mentioned that earlier as one of the positives of the role. – GO4.

The healthcare manager is excellent in terms of recognising if you need the help and doing something about it; because she will do something about it. So, I think in that respect, erm, there is support there, i.e., if you asked for it though, obviously. Erm, and the team support leaders, as well, they'll give you the support. – GO6.

However, some other participants expressed reluctance in seeking assistance from the healthcare governance managers.

I see them as a last resort. If you can't solve it yourself and you have no one else to ask, then ask a line manager. Otherwise, I am asking for trouble. I've been…I know how my line manager works now. – GO1.

Erm, but we are all capable of sorting out a lot of these problems. We don't have to keep running back to them. We need to go and tell them when there's something we can't sort out – definitely. That's the escalation thing, but I think they are very supportive of us when they can be, when the time allows, erm, but they are like the rest of us; they are under pressure. – GO3.
…but, sometimes, you feel as though 'maybe I shouldn't ask them; I'll just try myself to do it' [laugh]. There is that aspect as well, erm, but very supportive, if you need it - but I think you have to be desperate to actually ask for that help. – GO6.

GO5 reported that he did not think that support from the healthcare governance managers was always readily available. The participant felt that the training that was provided at the start of the job was inadequate.

…. I just want to say we don't work as a team. We are just told what to do like small children. They are the adults; we are the children, and that's the attitude and it's very unprofessional. Somebody within the governance meeting should have put a complaint against certain individuals in the team, but I haven't got time to do that myself, because I'm not interested. – GO5.

...you try to keep on top of things and you might be OK for a couple of months or whatever, but as soon as you miss something, erm, sometimes, they say they give you the support, I don't think they do, really. They do to a degree, but if you miss anything, it's still

your fault because you've missed it. Erm, but I'd say, 'Nah! I don't feel good'. – GO6.

When I started, I had to do everything myself. There was no support. There was no structure for someone new to come in and learn from. You just had to sit with someone and understand it. Or you have to go away and read the policy – God knows how many times – to understand it. – GO7.

They were reassuring that 'Oh! It will take you time'. It was all very reassuring and everything, but at the end of the day, when I went to my first governance meeting, I was there by myself. I'm spouting all this stuff to them and I don't even know the full story. So, it's like you are expecting me to go and tell them what you told me, when I don't fully understand what you told me. – GO7.

One governance officer was especially vocal against the managers in the Governance Department. This governance officer put forward a powerful and passionate argument that the governance team was not integrated.

We work in a pyramid hierarchy. The head of governance works in her own little box. OK? She works in her own little box. The next tier of management work in their own little box, and then, GOs work in their own little box, yeah? This is not an integrated team. That's why I said, I've worked in better team networks than this… You've got head of governance and you've got middle our next layer of management and they are not working together. There seems to be an issue between these two groups and it impacts on our work. We are not a team.

He continued,

I think we won the Royal Awards a couple of years back and it was the whole team that contributed to it. And you said to me the question, 'Oh! Do you think this is a team?' No, it is not! Because certain individuals got invited to the Royal Awards and they got, er, the medal on behalf of the team. But it wasn't an individual management thing – it was a whole team. And I think the GOs really felt annoyed there. Like they worked really hard and they got no reward…and that that is the attitude of this organisation. They don't reward people who, erm, contribute positively into the organisation. And, you know, that's one example I'd like you to put in the report. This is not a 'team team' thing because it showed, when that Royal Award was given, it was given to two individuals – but then, the chief nursing officer came over and said, 'Oh, it's a

team thing'. No, it's not! Don't put cotton over my eyes. It was an individual(s) who got that and we, we, as a team, felt very badly let down.

Lack leadership, lack innovation…lack motivation, they've got no foresight and they don't know how to, er, promote and, erm, they don't know how to promote talent.

GO7 suggested that the healthcare governance managers should send information directly to the governance officers rather than indirectly, i.e., through the team leaders.

Er, there was an e-mail that got bounced around outside. Then it got involved with the healthcare manager, yeah? Instead of going (and it related to…The person who could answer it was the governance officer.), instead of just cc-ing the governance officer or sending it to the GO or anything like that… instead, it was sent to the team leader. Why go through all that, when you could have just cc-ed him in and you would have got the response you wanted? My issue with the NHS, in this department, in the NHS, in general, is inefficiency. – GO7.

The fear of criticism was highlighted by GO6 as the reason why some governance officers were reluctant to speak up in team meetings.

That's why people don't really communicate in that meeting, because they are frightened. I think they want to be open. But yet, when you give an explanation of things, they don't always see that – they talk you down. – GO6.

But it just seems we get more and more and more work; more and more bugged down; more and more deadlines. If you don't meet your deadlines, you feel almost like a child getting told off! [shout and laugh]. You do! You feel like a child getting told off. – GO6.

4.2.3.3 Theme 3 – subtheme 3: Relationships between governance officers and clinicians

There was a unanimous agreement amongst the participants that it was very important to have good relationships with the clinicians, as this facilitated communication. The participants felt that their performance

would be negatively affected if they did not have good relationships with the clinicians. Although they viewed these relationships as important, they were often turbulent.

> *I understand that they are very busy, so I try to erm…, tackle…It's like…erm…If there is a request, for example, I will try to ask them once instead of many times. I think it is trying to…It is building a rapport with those…with those senior clinicians.* – GO1.

> *So, it is really important. Erm, we've got to work with these people on a daily basis. We have to get responses from them to make our job work. So yeah, it is very important for us to build a good working relationship with them.* – GO3.

> *I think the word that instantly comes to mind is fox, erm, because, certainly, from some of my clinical colleagues' point of view, I do go around late at night stealing things [laugh]. You know in the sense of a fox…A fox doesn't come out in daylight unless somethings are really bad. They only come out at night time and they pick off other peoples' rubbish. And that is kind of like what we do; we are not going out treating patients – we are going around and looking at what other people have done and, in this case, in the case of fox, what other people have put out.* – GO4.

> *And, eh, you know, as a GO, you need to be diplomatic, but you also need to be forceful 'cos, if you don't push the directorates in the right direction, they get away with a lot.* – GO5.

> *Extremely, very important. I think it's probably key. Erm, if you can build up some good relationships then, if you do bits for them, then they are more likely to answer your queries and get back to you. I think the more that you meet people, you try and get on with people and if you have had a bad experience erm, just let it go. Erm, kind of draw a line under it and move forward 'cos you need those people on your side, in order to get anything done.* – GO8.

GO5 considered himself fortunate to have good relationships with some of the clinicians he worked with.

> *Some of us have built those beautiful relationships with our directorates. I can't help it if I ring up one of my, erm, directors and call him by his first name, 'How are you doing? How are things? Wonderful! Fantastic!' and he is very helpful to me. That's not my problem. It's because I've built that relationship. And I've always*

said this and I'll always say it again. If you can't build that relationship with your team to ask either from the matron, CD or Directorate Manager, you are going to find it very challenging to work in that team. – GO5.

The convenor is a very good person to work with and so I do get something out of that; having that relationship with him and seeing some progress being made – that I do enjoy. Erm, I now meet with the matron and I do enjoy meeting her, because I can see what's going on: she gives me the information that I need and that's what it's all about; getting the information that you need. I don't mind going to meetings actually because that's, er… is an op..., gives you the, erm, opportunity to meet them and to get something out of what they are actually doing as well. – GO7.

GO2 said,

I have not been in a department from my directorate where I have been treated differently because of my grade…within my role and my day-to-day job, I don't have any issues with my consultants I work with. They talk to me with respect. They will not… Even, if they think I'm wrong at the time, say, we are on a ward and they think I am wrong, I'll be sort of side-lined as to, they will do the talking, then they'll tell me privately, 'Look, this is actually wrong, we need to…' They wouldn't do it in front of the people. So, that is showing professional courtesy. – GO2.

Erm, matrons...I have a good relationship with them. Group Manager, I pick up the phone, talk to her and I think because I've worked with them before, I think that's what's helped. …because I know how to approach them. – GO6.

GO6 explained the importance of maintaining good relationships between the healthcare governance managers and the clinicians.

Because you are taking instructions from the healthcare governance managers, but also, you are having to provide the service to the directorates. Some of it is standard, but sometimes, they ask you for ad hoc information as well. So, we are caught in the middle by having to deliver the governance agenda, but also provide the service to the directorates, but understanding what they need probably, in addition to what we are already doing. So, that's quite difficult and if you obviously haven't got a good working relationship with them, it is almost impossible to work with them. You can't get your work done. – GO6.

Some other participants said that they sometimes struggled with their relationships with clinicians.

> *…potential obstacle straight away is that the directorate you are working for see you as part of 'something other'. They don't see you as part of their own team, although technically, we are paid out of the different Divisions and the directorates work for the Divisions. The directorates see us as part of Governance; we are not part of them. Erm, but then again, when they want something from Governance, we suddenly become part of their team*. – GO4.

> *Erm, there was a lot of blocks put in front of you and if you wanted to make a telephone call to speak to the convenor, he said, 'Oh, go through my secretary, if you want a meeting'. If you want to discuss something you have to arrange a meeting. So then, the barriers are up; you can't have the free flow of communication which is what you need. And for me, that was very, erm, disconcerting. I didn't enjoy that at all.* – GO6.

Some of the participants explained the different strategies used by governance officers for effective communication with the clinicians. These approaches made their tasks easier.

> *For one of my areas, if you arrange a meeting with the audit convenor regularly (I used to arrange meetings but now I've found out – never arrange meetings.) they don't work. So just turn up. That works. It's how they like to be communicated.* – GO1.

> *You know, we say to them, 'If you are too busy, Dr. So and So, could you allocate this piece of work to another doctor? Somebody under you, perhaps, one of your SHOs or your registrars. Sometimes, you will get a good response, but still with some of them, they just will not respond.* – GO3.

> *…clinicians, they don't do things 100%, so we've got to say to them, 'Look, I 'll do 30% of this as long as you do the remaining 70%' and they normally do it, 'cos there is interest in there. They never do everything. It's something that you learn as you're doing the job. For example, NICE Guidance, they'll only do that if they are 100% compliant, but if there's an action plan to be done, you have to like, project-manage that action plan.* – GO5.

> *And I've noticed that quite a few of them enjoy listening to themselves speak. So, when I figured that out, I thought, 'OK, I'd just give them. I'll give them all the information and they can say everything'. And since then, it has worked out fine.* – GO7.

> *Yeah, erm, I kind of take different approaches depending on who I am speaking to. Erm, because obviously I know them a bit better now. Sometimes, it's easy to explain to them why you need the information. Erm, and what you are actually wanting to achieve and that kind of seems to help things along.* – GO8.

> *Other people, erm, I'm very aware that it's just, 'No, I'm not just doing this 'cos you asked for it'. So, I tend to just kind of agree with them. You know, when they are like, 'Why are we doing this? This is a waste of time.' I say, 'Well, you might find this is a waste of time, but we'll do this – but I understand where you are coming from'. I kind of just try and settle it that way.* – GO8.

The participants advised that they sought information from other members of the team, e.g., the directorate managers and matrons, who were usually relatively easier to approach than the clinical directors.

> *That's why we send a lot of our urgent work by way of the directorate trio. You know, we've got a manager to speak to, if we are really desperate, we've got the clinical director and we've got Matron. And there are also managers and doctors under them that we need to approach.* – GO3.

> *So, I do find communicating with them a bit more difficult than say, the directorate managers or even the matrons – I find that they are more happy to engage. I think they see more of it being relevant to patient safety which is obviously what it is about and I do find that they engage a bit better with me and, erm, they want more information and reports and they want feedback on how to improve things. So, I do find it a lot…a lot better.* – GO8.

The participants felt that clinicians saw governance as a burden, especially, as these clinicians had a lot of important and sensitive issues relating to patient care to address. To the clinicians, these clinical issues were higher up in priority than the governance-related issues.

It's way down their list of priorities. So, I think we have to be mindful of that. Just because our managers are telling us they need a response on something, erm, it's not going to be the burning desire of the consultant to help you out in the next half an hour and give you what you want. So, then you have to look for ways around it, you know. – GO3.

They are lifesavers; they are brain surgeons or heart surgeons or whatever. They don't see what we do as important and they think we are just box tickers at times and that is frustrating, but when they take it out at you in a meeting and really kill in almost, that is difficult to deal with. And I've got quite broad shoulders and I can always give a little back. It's kind of…but you expect more from them. They are clever men [and women] sorry! But majority of the rude ones are men. – GO3.

Other governance officers were of the opinion that some clinicians lacked an interest in governance-related issues.

I think that in terms of governance, they don't care. That's the impression I get. They don't care. The one who cares is the clinical director. The one who is on top of it all, i.e., *who will be responsible for everything at the end of the day.* – GO7.

…there are individuals who are not interested in the governance agenda and I think it is partly because they don't see it as part of their wider remit. Or they don't see it as part of their remit. Governance, you see, is not…What we do in this office, in this department, [in this building] erm, is not 'governance'. We don't do 'governance'. We are a Governance Department, but we aid others to carry out their obligations that relate to governance. – GO4.

One of my clinical directors…I had two governance meetings. Well, one governance meeting, and then I had a pre-governance meeting with one of my other directorates - separate directorates. So, when I told him this and I told him I just came from a governance meeting, he was like…he was like…and his expression was like 'God! You've got two governance meetings in one day! How do you do it?' [laugh]. So that expression alone tells you what they see governance as. – GO7.

… Erm, they find it boring. They don't find it interesting. I know that for sure. They definitely find it boring and they are very unenthusiastic about it. I think that would…that sums it up: boring; it's boring to them and they are very unenthusiastic. – GO7.

And they are difficult meetings at times and they can be full of aggressive clinicians, who have had a really long week and they don't want to be sitting in a 3-hr governance meeting looking at incidents and stuff. – GO3.

The big turnout that I mentioned earlier, that only happened because later on, I found out it's in the consultants' contract. They have to attend so many [X] amount of meetings, otherwise, they will be, erm, now, what's the word for it? I don't know, they get slapped on the hand or something. – GO7.

Like…this is just some of them, obviously. It's not all of them. Erm, but, like I'm bothering them. That they've got far more important things to do: saving lives – than responding to an action that was due two weeks ago or this NICE Guidance that was meant to be reviewed. Erm, yeah. – GO8.

On the other hand, some participants believed that some consultants were happy to meet and discuss governance-related issues with governance officers.

Yeah, erm, I find…to be fair, there are some consultants that, erm, I liaise with that are very happy to talk to me and give me the information and they don't… I don't know whether they do see it as a burden, but they certainly don't come across like that. – GO8.

Consultants? Erm, extremely busy. I find some of them very helpful, really nice. Erm, I haven't had many bad experiences, to be honest. Erm, they seem to take more of a lead, erm, on things and kind of…if there's junior doctors doing audits or anything like that, then I'm more likely to go to the consultant, erm, who's supervising them and they kind of get in contact with the juniors and it kind of works that way for now. – GO8.

Participants stated that there is a difference between the temperaments of a surgeon compared to that of a medical doctor.

Yes, there is a huge difference and again, it's people. I know there is a huge difference between the surgical side and medical side in terms of people. I've noticed that when I talk to some surgeons, the way they talk…rough! [laugh] – GO7.

Definitely, I think the surgeons are very much, erm…The medical side, I feel, are more engaged and more approachable. Erm, and

they've got more time, I feel, for you to go and see them. It's not with all of the surgeons, erm, but I do definitely, see a difference in how they respond to me, erm, and how they are in governance meetings and what they feel as a priority to speak about. Erm, whereas, the medical side, I do feel, concentrate on governance a bit better than the surgical side – they tend to bring in a lot of other issues that, maybe, they could discuss at a different forum. – GO8.

Medical... are really good. Erm, I have not been in a department from my directorate where I have been treated any differently because of my grade. I am…If I've said to a consultant, 'Look. I'm doing these bits and I'm….' They have worked to it and they haven't questioned it. – GO2.

…they (medics) will do what they have to do. They won't put up a fight. They will at the beginning, but once you give it to them, then they'll realise, 'OK. Let's just do this, so they can stop talking to us'. And it's that. So, they just do it because they don't want us to get more involved or they don't want any hiccups, they just want you to go. Tick box! – GO7.

4.3. Summary of the chapter

This chapter has presented the findings from individual interviews. The main themes from these interviews were: the governance officer role; pleasures and pains; unity despite diversity. The interview data suggested the value of extending the research questions and to probe experience in a different way. This was done via a focus group that addressed the additional research questions which were not answered by the individual interviews. The next chapter will present the findings from a focus group which was conducted much later with five participants.

Chapter Five

Findings – Focus Group

5.1 Introduction

The previous chapter presented the findings of individual semi-structured interviews. The purpose of this chapter is to present the findings of the focus group that was held with five participants. The themes that were identified following the analysis of the focus group are presented.

The focus group was conducted to answer research questions that relate to how governance officers ensure accountability at the local level of the NHS. The data were analysed using Braun and Clarke's (2006) approach and it addressed the research questions below:

Question 1: How do clinical governance officers narrate their roles?

Question 2: What is it like to be a clinical governance officer within the UK NHS accountability framework?

Question 3: How do clinical governance officers describe and experience accountability mechanisms in their local environments?

Question 4: How does the practical engagement of the clinical governance officer affect their sense of self?

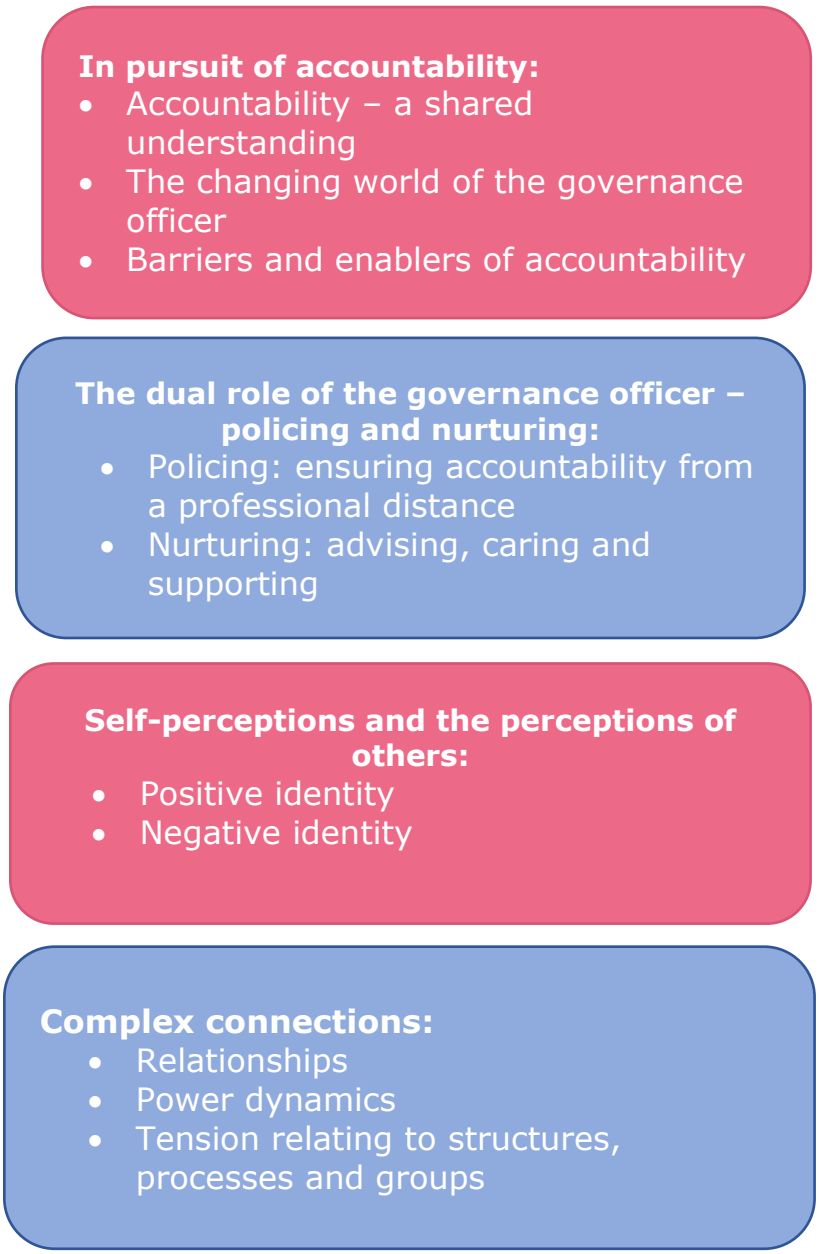
Question 5: How do power dynamics influence accountability within the NHS?

Question 6: How can the role of governance officers be conceptualised in terms of a discrete Community of Practice within the wider landscape of NHS practice and accountability?

5.2 Themes and subthemes identified following data analysis

The four themes that were generated following the data analysis of the focus group were: in pursuit of accountability; the dual role of the governance officer – policing and nurturing; self-perceptions and the perceptions of others; complex connections. These were further analysed into subthemes as seen in Figure 7.

Figure 7: Themes and subthemes developed from Focus Group



Below are the details of the themes and subthemes, including a selection of illustrative quotes.

5.2.1 Theme 1: In pursuit of accountability

This first theme relates to the participants' general views on accountability in relation to their roles as governance officers. It

incorporates their understanding of accountability, discusses how governance has changed over the years and reviews the factors influencing accountability. The issue of accountability was the mainstay of discussions during the focus group. The interview questions directed the discussions towards accountability; this was required to answer the research questions.

5.2.1.1 Theme 1 Subtheme 1: Accountability – the governance officers' understanding

This theme represents the participants' attempts to describe the meaning of accountability as it relates to their roles as governance officers. Various meanings of accountability were put forward by the participants.

> *Responsibility.* – GO1.
>
> *Assurance that everyone out on the wards are working to policy. It is making sure that everyone is doing what they are supposed to be doing.* – GO2.
>
> *Ownership.* – GO10.

GO9 pointed out that there was a difference in his understanding of governance and accountability.

> *… there is governance as well as accountability. In the Trust I came from governance staff were quite clearly not accountable for what clinicians did. It was never discussed*.
>
> *It is clearly a professional accountability, which is, if you are a registered healthcare professional, you are a member of a profession which has a code of conduct and GMC [General Medical Council], NMC [Nursing and Midwifery Council] or any other professional body.*

Then, there is everybody else who has a different kind of possibly less explicit accountability, which is where governance officers sit.

5.2.1.2 Theme 1 Subtheme 2: The changing world of governance officers

This theme represents how the participants saw the world of the governance officer, as discussed during the focus group. Frequent references were made to the changes that had occurred within the governance officer role over time.

Some governance officers felt that support from the executives and a change in culture had made clinicians more accountable.

> *I think it is easier now. Now we've got, erm, Divisional support – it is mainly easier.* – GO1.

> *I think it is the change in culture as well. It is more… moving towards open honesty. That is becoming more… moving in the right direction rather than the blame culture, where people were willing to sweep things under the carpet if they did not want to be accountable because of the consequences, potentially.* – GO10.

> *Thinking the barriers are lifting a little bit, so it makes it easier to be …to get accountability.* – GO10.

GO2 highlighted that there had been a shift in responsibility over the years.

> *Going back a couple of years and…, you felt responsible that the directorates are not achieving as they are supposed to be achieving. That caused massive tension. The accountability is with them - which it should be; it is their areas. And so, I think the tension has come down.* – GO2.

> *… I think that it is a lot better and it has made a lot of difference, moving basically, to Plan B with the directorates being accountable for their own areas. Because moving to a few years ago, that was not the case and there has certainly been a big shift within the last 12 months, of that happening.* – GO2.

5.2.1.3 Theme 1 Subtheme 3: Barriers and enablers of accountability

'Barriers and enablers to accountability' is one of the subthemes of the focus group that the participants spent a lot of time discussing. This subtheme focuses on the participants' perception of factors influencing accountability, i.e., the barriers and enablers of accountability. This includes the structures and workstreams that have been put in place to ensure accountability.

Barriers to ensuring accountability

Some of the participants talked about obstacles that governance officers face in the pursuit of individual accountability. GO8 highlighted that the clinicians were busy and they placed more priority on caring for their patients than addressing governance issues.

> *How busy the staff are out there… Erm, their first priority is their clinical duties. And then, if you need a response on a NICE [National Institute for Health and Care Excellence] guidance or an audit, that comes second.* – GO8.

GO1 felt that the non-engagement of clinicians could be due to the inadequate background information that was given to them by governance officers.

> *…because when I first started, we had a lot of tasks coming from managers or the team leaders. We were not told where the information feeds into or what it was for. So, they were weary to engage.* – GO1.

It was felt that clinicians do not acknowledge that governance is their responsibility; hence they do not see the need to be accountable for governance-related issues.

Er, I think it's easier once the directorates fully understand that what you are doing is for patient care. Erm, they see their roles as very clinical, and governance? Well, they are certainly used to seeing governance as kind of an add-on. It is: 'This is being requested by Governance; we need to do this for Governance', 'Just get this documented for Governance.' And I think working with them and making them understand that it is not 'Governance'. It is not one department that is Governance, you know, it is…it is part of their job.' – GO8.

There was some concern that low staffing levels, which necessitated extended governance officer cover, brought about restrictions on the level of support that governance officers could provide. The participants commented that this impacted negatively on their ability to address necessary issues in depth.

I haven't got time. – GO1.

…like NICE Guidance, if I don't get a response, I would chase and chase, but now, I only chase once. – GO1.

... if I had capacity at the moment in order to follow things up properly. At the moment, I don't have that, because we are all covering. – GO8.

Well, in the last couple of months, things have been quite busy? 'Cos we've had three governance officers leave and another go on to another position. So, we've had to take on extra work and I haven't been able to put into my work the standard that I would want to. So, I can't follow-up on things as much as I want to. So, I have been doing the bare minimum. – GO8.

That's what you really enjoy. The…, you know, when you are not just doing the bare minimum. You want to actually deep-dive into some things and feel like you are really making a difference. – GO8.

GO8 acknowledged the limits of competence of governance officers.

Erm, certainly, we can advise but we are not clinical. So, as GO1 said, you will get that barrier, yeah. 'Cos we would not see things from their point of view. We won't necessarily see their obstacles by implementing a certain action. – GO2.

GO10 felt that the general consensus was that it was tough to get people on board.

> *…everyone is saying with regards to the obstacles that they experience and you know, sometimes, how tough it is to get people on board.* – GO10.

Enablers of accountability

GO1 saw the improvement on local accountability in terms of management engagement.

> *I think, erm, the directorate management teams, erm, they will need to be more engaged. It is not the same across the Trust.* – GO1.

> *More engagement, more understanding. I think the level of governance understanding is not consistent – that everyone understands.* – GO1.

GO2 and GO9 stressed the tools of information management.

> *Centralised database – you know, that everyone can submit to. Which I suppose HealthAssure is going to become and take control of governance.* – GO2.

> *What one of the things in the Trust I came from had was an integrated database where all the actions were on one turf. There was one meeting where the different kinds of SUIs [Serious Untoward Incidents] were reviewed. The way accountability worked in that Trust was that directorates had to go to the meetings and explain what they were doing which makes them directly accountable.* – GO9.

For GO10, a reward system seemed to be an improvement method.

> *Remind them of the consequences, erm, promotion. Promoting what is…I think the awards is really good. Erm, to encourage them to be accountable.* – GO10.

The option of having dedicated governance officers in each directorate was suggested by GO9.

I think one thing that would make a difference is if they had dedicated governance staff in the directorates who know their jobs really well. Which is a model where I sort of come from…that I have seen somewhere else.

'Cos when I started there, we had lots of 'governance officerish' roles based around individual services. And then they started recruiting local governance managers and then the numbers of the governance officers shrank.

The downside to that, for the governance officer, is that it starts making our post redundant.

Other participants expressed what they felt it would be like if they had offices within the directorates.

I shook my head when you said that because we've got some governance people out in the directorates and we still don't get the responses and... That's why I was shaking my head. – GO2.

It is going to be a lot of pressure for that individual to sit in that directorate. At the moment, we are not sitting in those directorates. We can escape and we can report elsewhere if we have got an issue. If you are under the same roof and you are sitting in that directorate, you've got no one to complain to, 'cos the person you will be raising the concern to is the person that you've got the concern with. – GO2.

The structures and processes that are in place to enhance accountability were discussed by some participants.

Attending meetings…like non-governance meetings, like table-tops or audit meetings, where you may have an influence. You are there to, erm, guide them, to put them right if they are not doing something, you know, if you are not following policy, guidance or whatever. – GO1.

Well, you've got your Integrated Governance Report which you send out and you table at your directorate governance meetings which escalate, erm, serious incidents. – GO2.

Like SUIs, where they are clearly not meeting their professional accountability, then we are involved in that. There is an element of us being involved in holding them to account. – GO9.

5.2.2. Theme 2: The dual role of the governance officer: policing and nurturing

Among the participants, there was a general consensus that governance officers have two main types of roles: they 'police' the clinicians and they also nurture them in a bid to drive the governance agenda. This theme is, therefore, divided into two subthemes: policing – ensuring accountability from a professional distance, and nurturing – advising, caring and supporting.

5.2.2.1 Theme 2 Subtheme 1: Policing – ensuring accountability from a professional distance

To ensure accountability, governance officers 'police' clinicians by following-up (sometimes termed 'chasing') on progress with tasks in order to receive assurance of the completion of a task. The participants strongly felt that clinicians needed to take up their responsibility. They were of the opinion that governance officers should not be made responsible for the actions or inactions of clinicians.

Some governance officers felt that clinicians should have total accountability for their performance.

> *Auditing…Advising when they don't meet standards.* – GO1.

> *…I'm answering this differently, because I don't see myself as accountable. I see it as out there, running their ward. They are accountable for their areas. I can advise, I can point in the right direction and do everything that is asked of me, but it is their accountability to ensure that their staff are working as per policy.* – GO2.

> *No chasing! Absolutely none! You don't get…It's their responsibility. You ask for something, they do it. I don't ...You know, there is none*

of this, 'Have you done this yet? Have you done this yet? Have you reviewed this? Have you added this to your plan?' Because you are then, the governance officer is controlling everything and is ensuring that everything is done. Whereas, if directorates want to be accountable, they need to own all of it. That is my opinion. – GO8.

5.2.2.2 Theme 2 Subtheme 2: Nurturing – advising, caring and supporting

This subtheme highlights the nurturing side of governance officers as they advise, care and support clinicians in their quest to ensure accountability at the local level.

Participants spoke of providing support to the clinicians as a main task; this includes guiding and advising them.

Giving them guidance, giving them advice and giving them support. Erm, nurturing them, building good rapport. – GO10.

Assisting them to achieve…Giving them that support, creating that culture that we are there to support them. – GO10.

Another participant spoke about how, on some occasions, they carried out tasks on behalf of some of the directorates that they supported.

I think because we work so close with them, sometimes you can feel accountable yourself. So, if you are not getting any updates or things aren't done, if you are not getting things back in time, you kind of… you can put that pressure on yourself; that 'it is me that needs to do this one, not them [the directorates]'. – GO8.

GO10 stated that governance officers apply different approaches of communication for the different personalities in order to ensure that the tasks were carried out.

…that they are all very individual, they are all very different. To get the results, you would have to use different approaches, different methods to be able to glean what you need. – GO10.

5.2.3 Theme 3: Perceptions of self and others

This theme relates to the professional identity of governance officers. The governance officers gave both positive and negative insights into how they felt and how they felt that they were perceived based on their experiences. The two subthemes (positive identity and negative identity) are considered below.

5.2.3.1 Theme 3 Subtheme 1: Positive identity

Some of the participants highlighted positive perceptions: satisfaction and pride that their jobs gave them. They talked about the confidence they felt when they had the right information at their disposal.

> *It makes me feel proud when I can challenge*…– GO2.
>
> *Yeah, when I can challenge. You feel confident that you know you were right. You can go in there and then they come out saying, 'Yeah, we are going to have to do it' [laugh]. Because you've got that conviction, but that comes with time and, I suppose, being with your directorates for quite some time, you know.* – GO2.
>
> *I'm not afraid to challenge and I think that is key, you know, as well.* – GO10.

GO10, however, said that she felt overwhelmed with the diverse nature of the governance officer role. Notwithstanding, she perceived that the role of a governance officer was worthwhile.

> *Overwhelmed! [laugh] Yeah, I think there are a lot of elements to it. I haven't been on the job long enough and I haven't been able to experience what everyone is saying with regards to the obstacles that they experience and you know, sometimes, how tough it is to get people on board.* – GO10.
>
> *Making a difference. Making safer practices for patients*. – GO10.

GO8 said she felt that added experience on the job had earned her more respect from the clinicians.

> *I feel I've got a lot more respect from the directorates now than when I did when I first started – but that's been three years in the making. It's taken a long time for them to really…I think they now know that I know what I am talking about. Erm, so that feels good that they respect me a bit more now.* – GO8.

5.2.3.2 Theme 3 Subtheme 2: Negative identity

The common thread for this subtheme is the participants' perception that governance officers are not regarded as important members of staff by clinicians and managers. Their perception is that they are seen as low-level staff.

> *They see us as junior staff, sometimes.* – GO1.
>
> *Yeah; as a Band 5.* – GO8.
>
> *You don't have that authority.* – GO8.

One governance officer said that he felt demoralised with his experiences on the job.

> *… 'Cos it is contrary to most of my experience of working in Governance. I mean, they were to an extent… You know, that is just something I have to work through or leave, to be honest.*

5.2.4. Theme 4: Complex connections

This final theme relates to the network of relationships that revolves around the governance officers in their pursuit of accountability. Different types of relationships were formed amongst different groups. These were, sometimes, characterised by power and tension. The theme is divided

into subthemes: relationships; power dynamics and tensions relating to structures, processes and groups.

5.2.4.1 Theme 4 Subtheme 1: Relationships

Some of the participants felt that good relationships were important for the governance officers to have optimum performance. They explained how they maintained relationships with various stakeholders in the pursuit of accountability.

> *We are also accountable to the CQC, to the Commissioners and there is an internal accountability as well, which is what I think our role, I think, is – which is making sure that stuff that goes up the chain into Committee meetings and to Boards, for example. A lot of the work we do is about that internal accountability, as well, about the up chain.* – GO9.

One participant acknowledged the importance of building a good rapport with the clinicians.

> *… Trying to build, erm, good relations and good rapport. So, you got people on your side as much as you can and to identify when there is, erm, conflict within the directorates.* – GO10.

This participant said that it was not only important for governance officers to have close relationships with clinicians, it was equally important that they were centrally located as one team. This was so that they could learn from one another.

> *I think it's erm, you know, to retain the governance officers in our erm, department is quite good - rather than having individuals for each directorate, because at least, when you ……You can kind of pick up some stuff like good practice and reciprocate it across other directorates; tips and suggestions, and whatever. So, you liaise and you can move across directorates which I think is quite…you know, is positive.* – GO10.

5.2.4.2 Theme 4 Subtheme 2: Power dynamics

Developing and maintaining relationships involve power dynamics. Governance officers form a network of relationships with more powerful groups of staff within the Trust. One participant commented on how governance officers indirectly exerted some amount of power, e.g., via reports that they produce for meetings, such as performance review meetings, Divisional governance meetings, etc.

> *Erm, when we give our reports, that challenges. So, it is a good way to challenge the directorates.* – GO2.

However, another participant felt that being a governance officer was hard and challenging.

> *Sometimes, like you are fighting a losing battle, to be honest.* – GO8.

Some participants described the power game that was played by some senior clinicians and the influence they have on the rest of the team.

> *I mean, I've sat in directorates where they are (the clinical directors are). They send some quite obvious signals to let known to junior staff what they think of governance.* – GO9.

> *If they are not proactively engaged with you, then that sends a message to staff, I think.*– GO9.

> *Yes, I think that if the people at the top do not engage and take ownership, then it does not filter down to the rest of the directorate.* – GO8.

While commenting on how consultants and matrons relate, a participant felt that there was rivalry between these two staff groups. Another

participant remarked that some consultants could possibly be in a power tussle with matrons – this is not ideal for patient care.

> *… I mean, I definitely think there is a bit of a power struggle between medics and nurses which...I think there are some professional conflicts about control and power and influence, as well.* – GO9.

> *I think I can as well. I mean, I can think of one of the matrons that I work with who tends to…I think she is trying to recruit me into her side or in her ongoing and quite open conflicts with the consultants which puts you in a sort of difficult position because you've got to maintain your impartiality, but you can't without sort of overtly rejecting them. So, like GO2 said, you have to, kind of, walk on a tightrope.* – GO9.

> *…never once have I heard of a scrutiny meeting with a medic being there.* – GO2.

5.2.4.3 Theme 4 Subtheme 3: Tension around structures, processes and groups

There was a general feeling amongst the participants that governance officers experienced tension and stress as part of their role. This probably originated from the divergence between the clinicians' perceptions and the systems that were in place.

> *I think the big tension for us is with the clinicians. Their personal accountability does not map up with systems very well and I think that is where they get upset and that is where, potentially, some of the consultant challenges are.*– GO9.

Some of the participants felt that, in some cases, tension arose when staff groups did not agree with one another. There was a tendency for conflict, as each group strived to exert its authority, as explained in 'Theme 4 subtheme 2: Power dynamics'.

> *I think I get tension when I highlight something, say a Duty of Candour is applicable and then they come back saying, 'No, it is not applicable. All I did was miss this, but it didn't affect the outcome -*

> *and she (the patient) was given this'. You don't know that as a governance officer. All you are saying is, 'From what I am given, it is applicable…' You are not clinical, you can't make that judgment from, you know, what is in front of you. Sometimes, I have had quite curt responses.* – GO8.

One participant felt that the tension that he was experiencing on the job was making it difficult for him to adjust to working in an Acute Trust.

> *I do struggle. Partly because I came from…I think more because I worked in Community rather than Acute for a long time. So, I do find…to be honest, I find that the culture in the hospital is quite confrontational compared to where I have ever worked.*– GO9.

5.2.5 Summary of the chapter

This chapter has reviewed the findings of a focus group involving five governance officers. The main themes of the focus group were: in pursuit of accountability; the dual role of the governance officer – policing and nurturing; self-perceptions and the perceptions of others; complex connections. The next chapter will now discuss the findings from Chapters 4 and 5.

Chapter Six

Discussion

Individual Interviews and Focus Group

6.1 Introduction

This chapter discusses the findings of the study on governance officers, as revealed from individual interviews and a focus group. The previous two chapters revealed the views of the governance officers as they carried out their roles of ensuring accountability at the local level of the NHS. The findings of this study will be discussed in the context of the literature that was available and also in the context of the theories that were discussed in Chapter 2. The different perspectives of role theory will be the main conceptual framework (Merton, 1968; Biddle, 2013), Foucault's theory of power and Bourdieu's theory of habitus will be drawn on, where relevant (Gordon, 1980; Raffnsoe, 2016; Raffinsoe, 2019).

This is the first qualitative study to explore the role of governance officers within an NHS Trust. The findings add to the body of knowledge about how the quality of patient treatment and care is enhanced within the NHS. How governance officers attempt to improve upon the quality of care that is provided by the NHS by ensuring accountability at the local level will be the main theme of the discussion. Where applicable, patterns of convergence and divergence between the participants, and also between

the individual interviews and focus group will be highlighted. Finally, a summary of the chapter is provided.

The discussion is based on the research questions and it comprises three sections which are presented below:

Section 1: The governance officer – narration of role

Section 2: The governance officer – accountability and power

Section 3: The governance officer – issues of self and the dynamics of power

Section 1

6.2 The governance officer – narration of role

6.2.1 Introduction

This first section explores the perceptions of the participants regarding their roles as governance officers and what it is like to be a governance officer within the UK NHS accountability framework. As discussed in the sub-sections below, the key findings set out in Chapters 4 and 5 showed that the governance officer role is characterised by:

- Role evolution
- Role ambiguity
- Role overload
- Role conflict
- Role diversity

6.2.2 Role evolution

Significant change and innovation were the main themes in the early stages of the governance officer role. The available literature by Peak *et al* (2005) refers to 'Innovation – the development of new ways of working' as one of the three dimensions of clinical governance. Innovation is usually associated with change and this could bring about role evolution. The available literature highlighted that governance facilitators (officers) were the key persons responsible for improvement processes which generate change (Brown, 2005; Peak *et al*, 2005; Wall *et al*, 2006; Ward, 2009; Brockbanks *et al*, 2010; Russell *et al*, 2014).

The evolving role of the governance officer was a prominent theme throughout discussions with participants during the individual interviews. The governance officer role was evolving because the role was new and it had not been tested. Being a new role, it was dynamic and role scripts were always changing – even the managers were learning from issues that were arising. Governance structures and role expectations were constantly reviewed to meet the Trust's objectives. The goal was to provide a role with the expertise required to advise the directorates on all governance issues, rather than have one role for each specific workstream. It could be argued that role evolution was necessary, desirable and inevitable.

Role evolution has been described as sometimes being a positive and favourable occurrence, which could possibly bring about progress – it should, therefore, not be resisted (Belbin, 2013a). On the other hand, a social structuralism perspective of role theory states that roles are connected to structural positions and if the structures are shaky, there is a dangerous assumption that the roles would be the same.

The participants revealed that they constantly had to learn new role scripts. GO2, for instance, highlighted that governance officers were continuously learning. She saw this as positive, because it prevented complacency. The participants were sensitive to the governance agenda and they were keen to improve on it. It is possible that their personalities enabled them to facilitate change (Goleman, 2011). This is of particular

significance in the light of Lewin's (1947) freeze->change->refreeze model. Change enables individuals to learn new things and it could potentially open doors of opportunity for improvement.

Some participants revealed that role evolution led to increased workloads and the governance officers had to enhance their efforts to maintain efficiency. GO6 reported that at the onset of their role, there was a lot for governance officers to learn due to the large number of workstreams. This put pressure and tension on the governance officers, individually and as a team. It led to more indicators and more deadlines.

Team cohesiveness is likely to be in place where the members share a common task or have common problems (Mullins, 2013). GO1 and GO8 noted that they felt some comfort when they had problems, from knowing that their colleagues were also experiencing the same issue. Perhaps, at the inception of a role, there is more emphasis on structures than on the individual. The difference in opinions of participants regarding the evolving role depends on its relationship to the outcome of the interventions. Where the outcomes lead to improved patient care, role evolution could be considered to be positive.

Some participants noted that the evolving role of the governance officer was due to increased scrutiny by the Trust Board. The lines of accountability continuously change as the NHS evolves to meet economic, environmental, political and societal demands. Changes in policies have

influenced how governance officers carry out their work and also the volume of their workload. There is the possibility that the role of the governance officer could change again over time, which could possibly bring about further changes in accountability. The lack of stability of the governance officer role is inconsistent with functional role theory which, as we have seen, assumes that individuals occupy stable positions.

A number of participants reported experiencing tension as the role of the governance officer evolved. The difference in experiences of tension, between governance officers could be as a result of differences in capabilities, such as organisational skills, including time management. An individual's personality could influence response to stress, motivation and resilience which could affect role strain. Spurgeon (1998) has highlighted that the way in which individuals perceive stress varied from one person to another. Those situations that are perceived as unfavourable would potentially be classified as being more stressful. Governance officers who timidly felt that they were obliged to carry out all the tasks that staff in the directorates request of them would experience greater role strain, and especially more, if clinicians were not engaging with them.

Although role changes could be beneficial, they could affect job satisfaction and they are potentially detrimental to the morale of staff. Continuous changes to the nature of a role hinder role stability. This could make staff less secure, unable to settle down and unable to bond with their role-set (Maslow, 1987; Biddle, 2013). However, it could be argued

that as the role of the governance officer involves implementing change, change is inevitable within their role. The evolving role of the governance officer enables them to act as change agents, because they identify issues within directorates which could improve performance. The governance officer role has evolved over time in order to become established, it is unsurprising that the initial stages were not clear. Such situations lead to role ambiguity, role overload and role conflict, which are discussed in the sub-sections below.

6.2.3 Role ambiguity

The findings also point to the importance of role ambiguity. They show how there is a lack of clarity of responsibilities when the role expectations are unclear (Biddle, 2013). The scanty literature on the governance officer role itself reflects the lack of clarity around the role of the governance officers working in an NHS Trust. That the role was always changing meant that there were manifold levels of uncertainty due to the many changes. This was compounded because some of the healthcare governance managers who had the responsibility of clarifying ambiguity were also new to their roles. It was unsurprising, therefore, that governance officers were reported as being asked to carry out inappropriate tasks, such as chair meetings and take Minutes, on behalf of the directorates.

The available literature (Atwal, 2002; Seymour *et al*, 2002; Bower *et al*, 2004; Leigh *et al*, 2005; Franks and Howarth, 2012; MacAteer *et al*, 2016; Sutton *et al*, 2016; Chetty, 2020) emphasise role ambiguity in other NHS staff groups. As stated in Chapter 2, the staff groups that experience role ambiguity include palliative care nurses, mental health workers, lecturer practitioners; nurse consultants and occupational therapists. Like the governance officer role, these roles were reported as being relatively new. The lack of clarity in some roles was also due to their having dual responsibilities such as lecturer practitioner.

Some job contracts are purposefully ambiguous, with the role expectations on job descriptions stating that the role owner could be called upon to carry out miscellaneous tasks. This might explain why, during both the individual interviews and the focus group, governance officers highlighted that they were made accountable for some of the tasks that the clinicians had not completed. These are tasks that the governance officers do not have control over – devolved accountability.

Roles are taught and responsibilities of the governance officers are explained to them during induction and on-the-job training. The available literature outlines roles and responsibilities for some relevant staff, including lines of reporting and accountability. However, ambiguity in the governance officer role is seen in the data in Chapters 4 and 5. This resonates with Peak *et al's* early findings on misunderstandings amongst

directors and managers around clinical governance roles, especially, with respect to accountability, coordination and leadership.

During the individual interviews, the participants said that they had different approaches to ensuring accountability, and also different levels of academic qualifications. Governance officers were given on-the-job training upon employment. However, the lack of professionalisation – the process by which occupations acquire integrity and competence to enable them to transform into professions, might explain why governance officers have different approaches to ensuring accountability. This could also explain why there seems to be no boundaries to the governance officer role. The situation increases role strain, because the governance officers struggle between carrying out a challenging task, not being sure of the optimum approach to work and not knowing where their boundaries lie.

Confusion over boundaries has been characteristic of the governance officer role. But if it is regulated, the governance officer role could have unexpected effects. This includes not providing the flexibility that is needed for ensuring accountability amongst clinicians. However, the acknowledgement of role ambiguity in the governance officer role could usher in an opportunity for proper definition of the role.

Although governance officers have role expectations, this is sometimes disregarded by governance officers and managers, and they still carry

out miscellaneous tasks. Taking up responsibilities that are not assigned to an individual could be potentially risky, especially, if the outcome is unfavourable. There are also issues of accountability, i.e., where accountability for these tasks should lie. Governance officers could decline tasks and acknowledge the limits of their competence, but there was no report of any governance officer refusing to carry out a task. A possible explanation for this could be that governance officers want to please their line managers, and also the staff and clinicians within the directorates that they support. In addition, it could be that they are hard-working staff who are always willing to take on tasks assigned to them.

The relationships of governance officers are based on role-set expectations, i.e., actions and qualities, which give rise to behaviours as outcomes. Governance officers have different approaches towards ensuring accountability at the local level of the NHS. In line with early role theory, within each role, there are characteristic duties, behaviours and expectations (Linton, 1936). It could be queried whether total role consensus exists within the governance officer team where staff have an agreed and shared set of duties, values and behavioural patterns.

In spite of written job descriptions, the governance officers have different approaches to ensuring accountability that suit themselves or their personalities: ‘policing’ – ensuring accountability from a professional distance, and 'nurturing’ – advising, caring and supporting. The varied approaches used by the governance officers would produce different

levels of accountability. The approaches are influenced by the attitudes of the governance officers and the relationships that they maintain with the clinicians at the local level. This seems to deviate from the assumption of the functional perspective of role theory which suggests that people are taught norms and are expected to conform to them.

Role theory suggests that roles have characteristic behaviours – for instance, cleaners clean. Unlike the cleaners' job, it is difficult to discern what the role of the governance officer is from their job title. This is more confusing when the name of the role varies from one organisation to the other. Governance officers do not 'govern'. Findings from the available literature showed that, unlike in the viewpoint article, where the roles and responsibilities of staff were expressly stated and where there was an understanding of key roles, there did not seem to be a shared perception of the role of the governance officer. Since the term, 'Governance', is often misunderstood, it is not surprising that so also is the role of the governance officer. This raises questions about the role of the governance officer and its value in the healthcare system. It could be argued that this makes governance officers vulnerable within their role, because of the ambiguity that surrounds them.

The participants of the focus group too had mixed views about accountability and responsibility. They gave scanty feedback which reflects on their understanding of the term, accountability. This might have arisen from inadequate awareness and communication. There is no

doubt that adequate knowledge around individuals' responsibilities removes elements of role ambiguity.

This group of governance officers' level of understanding of the terms, accountability, governance and responsibility, resonates with Peak *et al's* (2005) findings that there is a lack of clarity around the term, 'accountability'. The authors also explored directors' and managers' understanding of the term, accountability, and they noted some confusion with the terms, leadership, accountability and coordination.

The constant addition of tasks to the governance officers' role and the evolution of their role, could lead to role ambiguity. Not knowing what they are expected to do could lead to a feeling of inadequacy, lack of confidence and confusion. Where this occurs, the governance officers might then be unable to carry out necessary actions and sometimes, they could make mistakes. Such role ambiguity could lead to anxiety, stress and health issues which could affect an individual's mental wellbeing and impact negatively on performance (Rizzo *et al*, 1970).

6.2.4 Role overload and role conflict

Participants reported that there were competing role expectations for their time and energy which led to role overload and role conflict. Role overload occurs when a person has many tasks to do at the same time and lacks the resources with which to accomplish them. Role conflict, on the other hand, is when a person has roles that are not compatible.

Many of the governance officers claimed that there was too much work from diverse workstreams. GO3 said that 'We have got work up to our eyeballs and we are stressed out'. When work is excessive, the governance officers might be unable to fulfil the expectations which are introduced by the role-set. For instance, the Duty of Candour was introduced as an additional process for managing incidents and this workstream has evolved. The additional workloads and their evolution sometimes led to role overload, with tight and competing deadlines.

The available literature agrees that this is indeed the case with some other roles within the NHS. For example, Chetty (2020), Sutton *et al*, (2016) and Nicol *et al* (2014) identified role ambiguity, role overload and role conflict in the role of some doctors. In addition, it has also been identified with some of the new advanced roles in the NHS, such as cancer nurse specialists, community matrons, consultant nurses, advanced nurse practitioners and palliative care nurses. These roles were reported as having ambiguity as a theme (Willard and Luker, 2007; Aranda and Jones, 2008; Peters *et al*, 2012). The findings develop the arguments of Schmidt (2000) and Biddle (2013), and they point to the extent of the impact that role overload has on roles within the NHS.

The participants experienced intensified role overload when there were staff vacancies within the department. This impacted upon the role expectations of the governance officers. It also brought about role conflicts, as it was sometimes a struggle to fulfil their own set of role

expectations and the role expectations of the vacant post. Role overload and role conflict decrease the number and frequency of positive interactions and could cause role stress which could precipitate as role strain. This has a tendency of affecting not only the individual, but the team and the Trust as an organisation. It could lead to a decrease in job satisfaction as the staff would no longer be motivated toward their expectations. Role strain also causes anxiety, frustration and tension.

For some governance officers, like GO7, role strain was said to be non-existent. He had no concerns about his workload. He attributed this to not being obliged to chase after clinicians whenever there was a lack of engagement. For him, the role of the governance officer was easy (a 'breeze'), as all he was expected to do was escalate issues to the managers. This participant said that he felt that the role of the governance officer was easy, because he realised early on that governance officers were not expected to chase after the directorates for updates of tasks done. Also, he realised that where directorates had done poorly (for instance, where they had not applied the Duty of Candour to a patient in a timely manner or they had not completed clinical audits), it was not a reflection of his capability.

The attitude of this participant suggests a sense of detachment from the performance of the directorates, an approach which was mirrored by some participants at the focus group. When the governance officers were detached from the directorates and they realised that they were not

accountable for their performance, they enjoyed their roles – their jobs were not stressful. The available literature (Nicol *et al*, 2014) suggests that some hospital registrars too were 'happy to work in ambiguity'.

Role overload and role conflict have similar consequences as role ambiguity; they are role stressors. If not properly addressed, these conditions could possibly affect job satisfaction and lead to low staff morale. They could cause a feeling of a lack of accomplishment, confusion, exhaustion and mistakes. This leads to anxiety, burnout, depression and exhaustion, stress, frustration and work-related ailments and could potentially affect the health and wellbeing of staff.

The work stressors can affect work performance and lead to diminished productivity. They lead to possible reduction in staff efficiency, as highlighted by GO7. This has an impact on the ability of the governance officer to ensure accountability. Although not experienced uniformly across the participants, this could affect the governance officers' work life. They could also have a negative impact on employee retention, achievement of organisational targets and organisational culture. A positive consequence is that following acknowledgement of role overload, a review could lead to an improvement in the role. Spurgeon *et al* (2012), for example, developed a cost-effective method of measuring role stress which could be useful for preventing organisational problems.

The notion that the role of the governance officer was a 'breeze' was, aggressively refuted by some other governance officers who felt that it was, generally, challenging and certainly, not 'a breeze'.

> *No! It is not a breeze! Definitely not a breeze! I don't think...No! Absolutely not a breeze. A breeze means that you just ...you ... everything is 'honky doory' – everything is fine. Everything is nice and gentle. A breeze! No, it's not! It's not a breeze.* – GO6.

These governance officers felt that their roles were challenging because they continuously demanded feedback from some staff within the directorates, to no avail. One way in which some governance officers addressed role overload was by prioritising their tasks. Some governance officers did not allow accountability to lay solely with the directorates. They felt that they were accountable if directorates did not perform up to expectation. Whether accountability should lay with the directorates or the governance officers, was an area of divergence. Clinicians have an individual accountability to the Trust Board to ensure that they provide quality care. The NHS is also corporately accountable to the patients and also to the public because the NHS is funded on tax payer's money.

There was a reported difference too in the workload for governance officers who worked in surgical and medical directorates. The medical directorates were described as 'the easy ones', e.g., Care of the Elderly, Neurology, Sexual Health, Dermatology, etc. These areas do not carry out as many procedures as the surgical directorates and, by extension, the governance officers who supported these directorates had fewer

issues to address. For instance, they would have fewer SUI actions, clinical audits, Duty of Candour, or risk management-related issues to address. The tasks of governance officers working with medical directorates are, therefore, not as heavy as that of governance officers who support surgical areas, as the latter areas usually have high patient numbers and high numbers of procedures. GO6 explained:

> *It depends on which of the directorates you work for. If you work for the easy ones, it is a breeze, isn't it? It depends on how demanding, how difficult your directorates are, how large they are, if they are, erm, compliant with you. That's when they could say that it's a breeze.*

In spite of the role ambiguity, role overload or role conflict that the governance officers had experienced, none of them reported that they had overtly complained to their line managers. These governance officers absorbed their heavy workload, without complaining or negotiating their roles. They were passive with regards the challenges that were associated with their role. Possible explanations for this could be because they are a disempowered group or they do not want to be seen as unable to cope with assigned tasks. Their concern could possibly be that they could be seen as incompetent, lazy, uncommitted, unwilling to work hard, or not being good team players. Some might argue that they see role ambiguity and role overload as inherent to their role. Others might want to remain on the good side of their bosses. While others, might be weary of speaking, as they do not want to be in the bad books of their managers. However, another possible explanation could be that the governance officers are extremely hardworking staff who have wholeheartedly

embraced their role in order to ensure high-quality patient care. In this case, these conditions would not cause them stress.

A number of articles have reported role overload and role conflict in NHS staff roles (Edwards *et al*, 2000; Seymour *et al*, 2002; Onyett, 2011; Franks and Howarth, 2012). Brown (2005), early on, argued that the role of a governance officer was challenging – but rewarding. The early viewpoint article by Peak *et al* (2005) also acknowledged the diverse nature of clinical governance and the accompanying difficulty that is experienced while managing the systems. Difficulties could arise as the various systems are being managed.

6.2.5 Role diversity

The participants saw clinical governance as having a vast scope. With the generalist role, the governance officers had to attend to many tasks. As a result of the diverse nature of their workload, GO1 described governance officers as 'Jacks of all trades'.

We have seen that governance officers have multiple roles including, administrator, adviser, analyst, co-ordinator, facilitator, guide, supervisor, trainer, etc. Apart from carrying out these tasks, they also take on roles of other persons employed within the Trust. The metaphor, 'Jacks of all trades', could also mean that the governance officers are capable of doing many things, but they are not experts in any of them.

As discussed in Section 4.2.1.1, the diversity of their role made the

workload challenging and overwhelming. They also had competing deadlines which were difficult to meet. Governance officers had to multi-task, be alert and also be proactive, if they were to be efficient and effective. Edwards *et al* (2000); the newspaper article, *Personnel Today* and Onyett (2011) reported how role overload and conflict in doctors and mental health workers' roles caused stress. This sometimes meant that they were unable to address governance-related issues thoroughly. It raises a question about the level of support that some directorates received and whether full accountability was always ensured.

The complex role-set that they have, i.e., interacting with many people with different personalities makes the governance officer role more complex. The perceptions of the governance officers differed with regard to the diversity of the governance officer's role. For some governance officers, the diversity enhanced their job satisfaction.

Role theory from its earliest formulations in the 1930s to more modern accounts such as that in Biddle (2013) helps to illuminate many aspects of the experience of the findings about the experience of governance officers. However, the addition of the formal accountability agenda which governance officers help to administer adds a dimension that the next section will explore. As role theory is inadequate in exploring the role of governance officers, Foucault's theory of power and Bourdieu's theory of habitus will be used to support this.

Section 2

6.3 Accountability

6.3.1 Introduction

The last section used role theory to explore the nature of the governance officers' role as narrated by the participants in the individual interviews and the focus group. This section uses Foucault's evolving theory of power to fill gaps in the thesis that have been unexplained by role theory. Foucault's theory will be used to explain how the governance officers' role is affected by discipline, surveillance and power relations. The section will also explore how governance officers, specifically, interact with consultants in order to ensure accountability at the local level.

The discussion aims to address the research questions, 'How do governance officers describe and experience accountability mechanisms in their local environments?' and 'How do power dynamics influence accountability within the NHS?' The accountability mechanisms are, in this case, the scripts for behaviour that have been set for the governance officers in order to ensure accountability (Biddle, 2013).

The section first examines the nature of the accountability procedure as a form of governmentality. It then discusses the hidden side of accountability as a form of disciplinary power. It explores the findings relating to the power dynamics involved in relating with consultants. It also considers how issues of power influence the ability of governance officers to ensure accountability.

6.3.2 Trust governmentality, its formal procedures and governance officers

The notion of power is a key issue in explaining the role of the governance officer. Foucault looks at power contextually and describes the activities that are set up to control the conduct of a group of staff as 'conduct of conduct' or governmentality. He describes governmentality as the link between micro and macro operations of power whereby institutions use procedures, policies and tactics to govern individuals (Dreyfus and Rabinow, 1982; Foucault, 1991; Raffnsoe *et al*, 2016; Raffinsoe *et al*, 2019). Governmentality, here, can be described as the system of thinking about the nature of the practice of governance. Foucault describes it as the space that is occupied between governing of individuals and the governing of others. Governmentality also examines all the processes that relate to power within institutions.

6.3.3 Ensuring accountability – a collective organisational commitment

The literature review described accountability as a requirement that every individual is answerable and responsible for the outcome of their actions. The review also drew attention to Bovens's (2007) description of accountability as including personal, administrative, professional and legal accountability. These are linked with one another to bring about a collective organisational commitment to accountability, but they rest on personal accountability.

Personal accountability is important because a lot of the work that the staff carry out in practice is based on their independent activity. GO1, summarising his own sense of personal accountability, said that it involved taking responsibility for his work by carrying out the tasks on his job description and having transparent communication with the directorates. Administrative accountability of staff was ensured through the reporting channels to their line managers. In the case of governance officers, their line managers are the healthcare governance managers who, via supervision and surveillance measures described later in this section, ensured administrative accountability.

Accountability is a complex issue and it could be described as evolving around power play. It is important to highlight the power dynamics in the relationships between two parties where one party holds the other party accountable. For instance, regulatory bodies such as the Nursing and Midwifery Council and the General Medical Council were set up to improve the quality of patient care. They have the authority to ensure professional accountability and discipline. They set the standards for entry into the professions, have codes of professional conduct which are laid-down standards of conduct and practice that members have to adhere to, and they maintain confidence and discipline. This is, in itself, some form of power on the part of the regulatory bodies. With professionalism comes another kind of accountability. The clinicians are aware of their responsibilities and accountability to the regulatory bodies.

Consultants are highly-skilled professionals and as a result, have achieved a high status which gives them much power and prestige. It is arguable that, as they are keen on maintaining the power and prestige of their professions, they are oriented towards professional and regulatory bodies. In addition, clinicians are aware that they are legally accountable – as they could be struck off the registers if their conduct is found to be unsatisfactory (Flynn, 2002; Tingle, 2005). Hence, they would rather give clinical issues priority over addressing the Trust's governance-related issues. Workstreams carried out by the governance officers, such as Clinical Audit, Incident and Risk Management, NICE Guidance Management and External Visits, are used to drive accountability. However, those workstreams whose outcomes are relayed to the public tend to take priority. For instance, GO1 explained how some clinicians were more likely to apply the Duty of Candour if they were told that it was the law. This shows that there could possibly be some bias to accountability at the local level.

The Trust Governance Department has an explicit mandate to steer and direct staff working for the organisation, so that they can collectively commit to ensuring accountability. This instils some control and, therefore, accountability power. Managers lay down detailed instructions in the form of Trust policies. Although these can be waived with rationales, they are 'blanket' policies and are not always appropriate.

The participants' reports showed similarity to the descriptions of the workstreams in the available literature. These workstreams included Clinical Audit, External Visits, Losses and Compensation, Risk Management and NICE Guidance Management. The findings also support the discussions in the available literature which show that the governance officers/facilitators had additional tasks, such as attending interviews, workshops and ward rounds. The governance officers also coordinated peer review visits, quality improvement events and Annual Health Checks. The participants in the study talked about the Duty of Candour though, which was not included in the available literature. This workstream was introduced as a result of the changes that took place after the mid-Staffordshire NHS Trust inquiry (see Chapter 1).

Clinical audit is a common quality improvement tool used to ensure accountability in the available literature. Eleven articles out of seventeen articles discussed how audit was used to ensure accountability. However, audit can be seen as a type of modern surveillance (Raffinsoe *et al*, 2019). According to Foucault, surveillance is a mechanism through which an institution (or society) can try to bring about improvement in performance. In the NHS, clinical audits enhance accountability and they are in the forefront of quality improvement (NICE, 2006). Doctors are expected to carry out audits for the purpose of revalidation; this, in itself, is some sort of power. The historical underpinning of clinical audit can be understood from the Foucauldian perspective. The name changed from

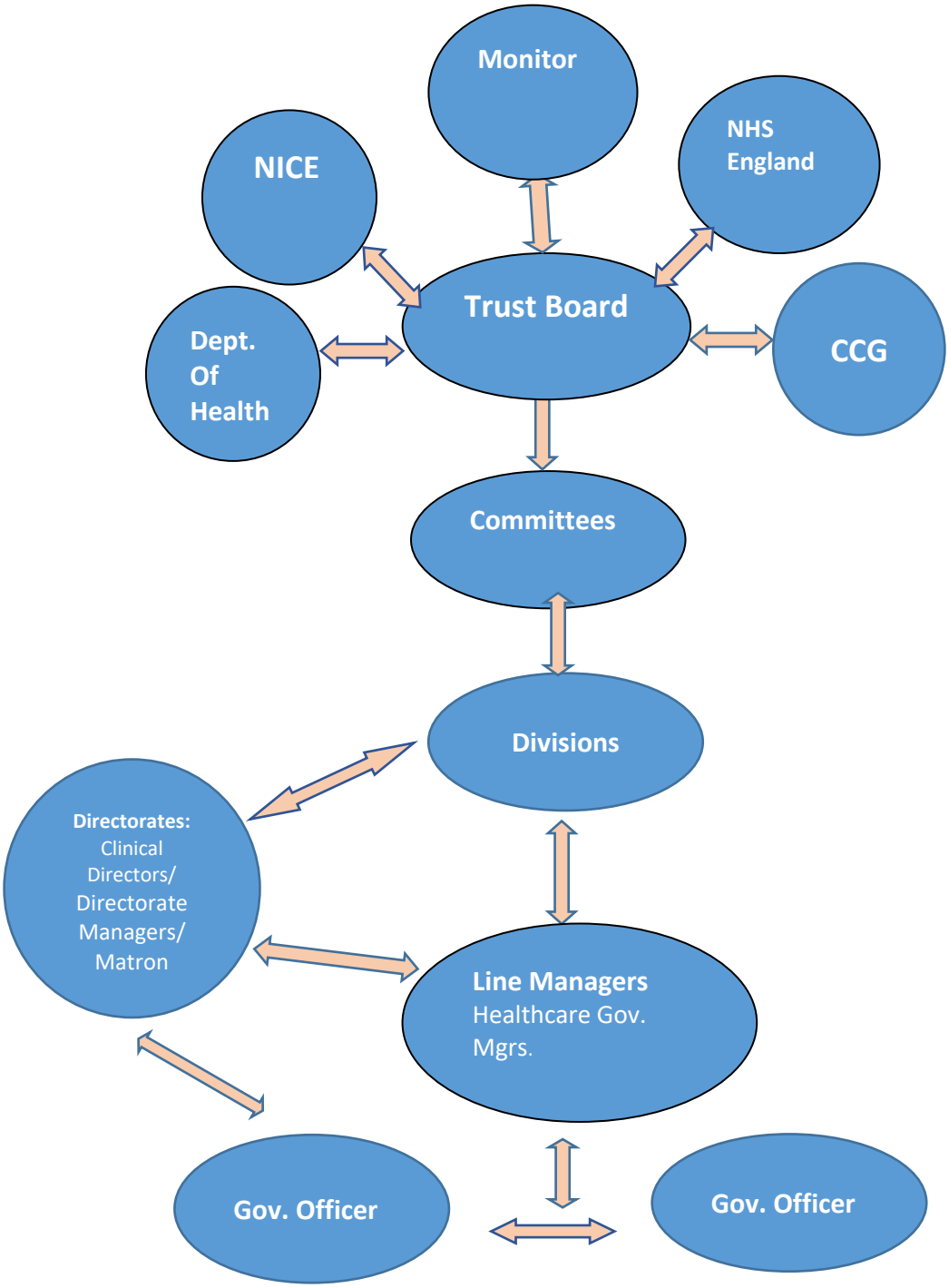
medical audit to clinical audit when the scope of audit was widened to include clinicians. Audits, such as the Consent Audit, the Discharge Audit and the Documentation Audit, were reported.

By facilitating audits, governance officers too ensure accountability and they also contribute towards quality improvement. Some of the participants described audit activity, the audit meetings that took place and how they met regularly with audit convenors. National audit results are sometimes published and good results restore the confidence of the patients. Poor results could possibly raise concerns about the quality of treatment that is provided by the Trust and reduce trust and confidence. Audits do not always bring about improvement in performance. Some clinicians were frustrated because despite carrying out audits, there had not been much improvement. This might explain their lack of engagement. Some participants felt that the clinicians' lack of engagement could probably be because they see governance-related activity as a tick-box exercise.

Some participants were concerned that there was misplaced accountability. Governance officers, for example, were sometimes blamed for non-completion of audits and also for the population of insufficient information on the audit database.

Figure 8 shows the complexity of accountability in H City NHS Trust and the varying and multiple lines of accountability.

Figure 8: Multiple lines of accountability in the NHS Trust



Governance officers also facilitated the management of External Visits, NICE Guidance and SUI Actions. The findings show that the ultimate aim of the workstreams was to hold the clinicians accountable and to bring

about a positive change in local performance. GO7 reported how clinicians had been made more accountable for the treatment and care that they provide to patients with the introduction of the Duty of Candour. The governance officers ensure that clinicians adhere to the Health and Social Care Act 2008, Regulations 14 (Regulation 20). This regulation makes it statutorily mandatory to be open and honest to patients if the Trust had caused them moderate harm or above. Therefore, governance officers ensure that clinicians apologise, inform the patient/family that the incident would be investigated and offer them the outcome of the investigation – within 10 working days of incidents being reported (Duty of Candour, Element 1).

By facilitating the Duty of Candour process, governance officers tried to encourage a positive culture of openness and trust. They make it comfortable to admit an error to patients, colleagues and the Trust without fear of rebuke or punishment. Some might argue that being transparent and having to be accountable to patients and the Trust reduces the clinicians' power. More power is placed in the domain of the patients and/or their families. The Duty of Candour also enhances shared learning and it is a means of improving the treatment of other patients.

External agencies, such as Care Quality Commission (CQC), the Commissioners, Health watch, Royal Colleges, international organisations, e.g., UNICEF, etc., visit the Trust. They attend either on assessment, inspection, accreditation, peer review, or on informal visits.

The governance officers help to manage this network of external power relations. Governance officers have the responsibility of ensuring that all discourses that are held are implemented.

The participants discussed how other workstreams ensured accountability. NICE guidance, for instance, makes sure that clinicians are accountable for providing the most cost-effective patient care. The workstream relating to SUI actions makes governance officers the bridge between the clinicians' accountability and the Trust's corporate accountability to patients. The Trust has a corporate accountability to ensure patient safety, while the clinicians have personal and professional accountability to patients. Following a serious incident (SUI), governance officers ensure that the SUI actions that are generated are appropriate and that they are completed in a timely manner, in order to prevent a similar incident from reoccurring. Balancing the need for accountability and ensuring a 'no blame' culture is not straightforward. However, a 'no blame culture' is important to encourage staff to report incidents and ensure patient safety.

The participants said that other areas where surveillance and the requirement for accountability were highlighted were in meetings. These meetings occur at the local, committee and Trust Board level. They include 1-2-1 meetings between governance officers and healthcare governance managers, appraisals, directorate governance meetings, divisional governance meetings, quality assurance meetings and scrutiny

meetings. Local performance is monitored and assurance is provided to Committees and the Trust Board. The meetings are also effective channels of communication which foster interpersonal relationships. They are direct means for governance officers to ensure accountability by obtaining feedback, ensuring clarity, resolving conflicts, and ensuring commitment to actions and responsibilities. Relevant information is documented in the Minutes of these meetings. Meetings also provide learning and development and they promote inclusion and equality. Appendix 16 shows an agenda of a directorate governance meeting.

Other meetings include risk meetings, team meetings and table-top meetings, where Serious Untoward Incidents are discussed. The meetings are important as they enable learning from mistakes, ensure that robust actions are put in place to prevent the incidents from happening again and also improve on patient safety (Benn *et al*, 2009). Some of these meetings are chaired by Trust executives and staff are invited to assist with the investigations. The executive level at which these meetings are held reflects the use of power in ensuring accountability. The focus group revealed that the governance officers were not completely powerless, as they escalated their expectations to these meetings where the executives ensure that robust accountability is ensured. In the available literature, Sykes (2020) states that in one Trust, high-risk audits were escalated to the Trust Board.

Surveillance by the managers has the ability to enhance accountability and encourage the staff to adopt personal responsibility. GO6 reported how the managers were supportive and how they ensured that deadlines were met. She specified how she felt when being told off for not meeting a deadline.

> *'If you don't meet your deadlines, you feel like a child being told off! [shout and laugh]. You do! You feel like a child getting told off. You think, 'I've tried to meet my deadlines, but there's lots of competing deadlines all the time.'*

The governance structure that was described by the participants was reflected in the NHS grey literature which include the Governance Strategy, the Risk Management policy and the Clinical Audit Strategy. The participants' reports were aligned with the three-pronged governance model that was developed by Peak *et al* (2005). This comprised of a process of accountability, assurance and innovation which are important for continuous improvement. It was also observed that the well-defined roles and responsibilities which were described in the model were similar to those that were described by the participants in the individual interviews and the focus group. Peak *et al* (2005) identifies innovation as the mainstay of the governance officer role which is aligned to what occurs in the Trust of study.

Gnani *et al* (2004), Mynors-Wallis (2004), Peak *et al* (2005), Wall *et al* (2006), Russell *et al* (2014) and Cole *et al* (2020) reported on a plethora of activities that they participated in. This includes the annual health checks, audit events, ward rounds, quality improvement events,

multidisciplinary sessions, randomised control trials and workshops. At these forums, the governance officers/facilitators were able to discuss issues of relevance with the frontline staff in order to bring about improvement. They seemed to actively reach out to the frontline staff in a variety of methods in order to move the governance agenda.

GO2 discussed how she visited the wards to talk to staff about how to report incidents. She said that she attended Mortality and Morbidity meetings. Another participant also talked about how she participated in an Audit Award Event. Other participants did not say whether they visited ward areas, attended Mortality and Morbidity meetings or participated in audit events. Generally, the data suggest that compared to the available literature, the governance officers worked in a 'strait jacket' with limited room for maneuvers. Reports of the participants in this study showed that the governance officers were not as aggressive or 'hands on' as the governance officers/facilitators in the available literature with their approach to moving the governance agenda forward. The emphasis for the governance officers, as reported by the participants, was on providing assurance to the Trust Board on local performance.

Generally, the governance officers in the study seemed to focus on operational workstreams and ensuring compliance to Trust policy. The discussions of the participants emphasised such workstreams as Clinical Audit, SUI Actions, External Visits, Duty of Candour, NICE Guidance, etc. Another area of disparity is that mechanisms of accountability discussed

by participants in the study, such as IGRs and attending a variety of meetings, were not reported in the literature.

It is worth mentioning though, that clinical audit was a common feature of both the study data and the available literature. As highlighted in Table 10, the available literature showed that clinical audit was facilitated by many clinical governance officers/facilitators. Audit was also reported by the participants of this study as an important component of the governance officer role. This highlights the significant part that clinical audit plays in ensuring accountability and improving the quality of patient treatment and care. It suggests that audit is an important surveillance tool used by the governance officers/facilitators.

Two key findings which flow from the study are that surveillance plays a major part in the role of the governance officers and that governance officers use different strategies to engage with clinicians at the local level. The consequences of H City NHS Trust for not participating or organising the quality events, formal ward rounds etc. are that this could negatively impact on relationships or team-building between the Governance Department and the wards. It could also impact on the management of incidents within the wards. It could influence the provision of safe, effective and high-quality care to the patients. Benn *et al* (2009) highlighted the importance of effective incident-reporting and suggested that not much work was being done on effective feedback within the healthcare system.

The participants discussed other ways in which they interacted with clinicians: via meetings, telephone calls and e-mails to discuss performance. This resonates with the available literature: Russell *et al* (2014) discuss how quality improvement facilitators provided support by communicating via e-mails, telephone calls and follow-up visits. The participants said that they offered support to clinicians, requested updates and provided the clinicians with information and general advice on governance-related issues. The participants also described how they produced and discussed monthly Integrated Governance Reports (IGRs) which highlight directorate performance. These are discussed at directorate and divisional governance meetings and also quality assurance meetings. Accountability is ensured because the staff are invited to explain their performance. Where the expectations of the Trust are not being met, there are consequences.

It is not surprising that there are multiple lines of accountability for clinicians – the Trust, the public and also their respective professional and regulatory bodies. Staff are accountable to the Trust through a contract of employment and also via their job descriptions that highlight the duties that are expected to be done, including compliance to policies, procedures and guidelines – employment accountability (Caulfield, 2005). They are accountable to the public because they are paid through taxation and they could be subject to litigation in cases of negligence. This makes the situation rather complex and although the two latter areas of

accountability are external to the organisation, they play an important part in adherence to codes of conduct.

Another issue in ensuring accountability is how to consistently measure performance improvement in all areas, apart from just clinical audit, without apportioning blame. Being able to measure quality improvement would enhance the ability of clinicians to be accountable. The results of a study by Armstrong *et al* (2018) about a quality improvement measuring programme, however, showed that there were concerns about controlling the risks of blame. The researchers claimed that clinicians would be less defensive and in positions to focus on improvement measures if there were 'no blame' cultures in place.

6.3.4 Governance officers, disciplinarity and micropower

Accountability has a disciplinary element. Foucault stressed how governmentality and the panopticon effect produced this. Governmentality in Foucault's initial argument implies that power shifts upwards and it is invested in procedures controlled by others rather than the professional ethics of the clinician. There are two forms of power; the first is from above and it is policed by others who are also subject to disciplinary power. Governance officers internalise the other form of power by policing clinicians so that they are accountable.

The hidden side of accountability is exhibited in the micro-relational powers which are expressed in everyday practices. These power games

are communicated via actions which are verbal, visual or written. They are imposed by the managers who dictate the behaviour and activity of the staff. GO4 explained how the healthcare governance managers used trackers to monitor activity of the governance officers. Governance officers could 'get into trouble' for not completing the trackers and/or not doing the task. Foucault linked micro and macro power levels by focusing on the government of individuals alongside the governance of the collective population (Raffinsoe *et al,* 2019).

The enforcement of Trust policies and procedures increases the power of the managers and this reduces the power and control of the clinicians. Surveillance enables self-regulation, controls behaviour and promotes discipline, as often staff are unaware that they are being watched, or when their work is being/will be scrutinised. This produces a 'Panopticon effect'. Managerial decision-making and consultation apart from increasing surveillance also reduce agency, i.e., the staff's ability to have a choice. GO2 talked about the set policies which staff have to abide by. These, together with the hierarchical structure that is in place, reduce agency for staff, including governance officers. GO1 said that governance officers were treated as junior staff and due to their relatively low status in the hierarchy, the governance officers would not have much of a choice on the actions or tasks that they perform. There is no reference to trackers or the enforcement of policies in the available literature.

It is debatable that the governance officers/facilitators in the literature had more authority, power and responsibility than the governance officers reported in the study. This is because of the nature of the tasks that they carried out. Their ability to facilitate change was independent of relevant others. Hugman (1991) in a pioneering study of power in the caring professions identified how some groups saw themselves as less powerful than others and explained how power is exercised from senior to junior staff. In the case of governance officers, the participants reported how they tried to meet line managers' expectations and the Trust objectives.

The different faces of power, decision-making power, non-decision-making power and ideological power, were present within this role-set (Bachrach and Baratz, 1962; Lukes, 2005). The two important staff groups (clinicians and managers) have decision-making powers that are used to ensure accountability. This relates, for instance, to the policies that have to be adhered to in order to change behaviour. Non-decision-making power would be utilised in cases where the clinicians are reluctant to co-operate. In some cases, the clinicians are side-tracked and excluded from decision-making by the managers so that they have no power to determine what happens, e.g., setting the agenda at meetings selects issues that would be discussed. Consultants can also exclude managers and governance officers on a day-to-day basis, etc. For instance, they just will not engage. As GO7 indicated, where a clinical director is not

interested in governance activities, he will not engage. This jeopardises the governance agenda. In such cases, there is a stalemate: the directorate does not benefit from the governance department and vice versa. Governance workstreams such as Audits, Duty of Candour, Incident and Risk Management, etc., would be ineffectively handled, thereby putting patient safety at risk.

The managers possess knowledge or ideological powers which is based on their ability to shape norms, change the culture and also alter the way in which staff engage with one another. Culture has been identified as a powerful force which dominates and embodies power relations (Navarro, 2006). As governance officers are relatively lower in the hierarchy than the clinicians, they do not have decision-making and non-decision-making powers over them.

6.3.5 Power dynamics involved in ensuring accountability

Consultants, managers and sometimes, the governance officers, were observed to have manifested power at different occasions. The participants' perception of consultants was that they are experts at the peaks of their careers who are powerful compared to other professions within the Trust. As reported by the participants, an obstacle to the role of the governance officers is the inadequate commitment and engagement of some consultants. Meanwhile, a lot of accountability is required from consultants as they have great authority within the Trust.

Some consultants seemed to prioritise patient care over governance-related issues. For instance, some of them have to be 'chased' or repeatedly sent gentle reminders in order to provide feedback on audit activity or in order to complete audit actions to bring about improvement.

Reasons why some consultants might not want to engage with clinical governance could be because it is target-driven, controlled by legislation and providing detailed instructions that tended to distort professional practice. It erodes the concept of trust. There is so much control and so much to conform to, that the clinicians might feel that if they engaged in governance, they would have little or no time to carry out their professional obligations (Watson, 2005). Where governance officers did not get the support of the clinicians with regards feedback, it caused frustration and tension, as reported in Chapter 4. The differences in knowledge, position and focus of consultants and governance officers could sometimes add towards making the role of the governance officers a challenging one.

Power is at the heart of social relations (Hugman, 1991; Swage, 2004; Navarro, 2006). Consultants hold a lot of professional power, resulting in their greater decision-making power. Governance officers hold them in high esteem. Their perception of consultants is due to the behaviour of these consultants, their knowledge, authority, and the confidence with which they carry out their activities – the embodiment of power.

> *They are very important people in the hospital. They are very professional and they do a wonderful job from the clinical side of things. However, they are quite powerful. They are at the top of their tree in their specialty and we do rely on them for information and to fill forms in, which they hate doing. And sometimes, you can, you know, you just find that they won't engage in the work that we ask them to do.* – GO3.

Furthermore, there is a big gap between these groups. The start salary of a consultant is £74,000 per annum, while that of a governance officer is £26,000. This is the annual salary for Band 5 staff that the participants indicated that they were on during the interviews and the focus group. The participants at the focus group felt that they had insufficient authority and power as a result of their Band level. It is not possible to discern how other governance officers/facilitators felt as result of their level, as there is no reference to power dynamics in the available literature.

According to Foucault (1980), knowledge is used to implant powerful discourses that influence the ways in which others understand reality. Foucault (1980) argues that for an individual to be empowered, they should have similar knowledge. The unequal power balance between the consultants and the governance officers, possibly stems from this unequal balance in knowledge and expertise (Hugman, 1991). The unbalanced power relationship between the groups could make it easier for the consultants to disregard the requests of the governance officers. Language is used in relationships within the role-set to reflect power and also to enhance performance. How language is used by the governance officers could possibly influence their ability to ensure accountability. With

knowledge comes an acknowledgement of those issues that are important. The discourse relating to the governance agenda changes with time – this depends upon the current environmental and political climate. In addition, certain workstreams, e.g., Clinical Audit, Duty of Candour, are given greater focus than others. These workstreams that are under greater surveillance will probably show better performance than others.

Some clinicians regard the bureaucratic documentation and other requests from governance officers as unnecessary. The participants said that a number of consultants felt that some governance-related tasks were tick-box exercises. The consultants might not see addressing these tasks as key priorities. Also, it is probable that they feel that addressing the indicators does not always bring about a direct improvement in practice and does not impact much on patient care.

It is not surprising, therefore, that the participants reported that engaging with some clinicians was sometimes challenging. GO3 said that he came against a brickwall when the clinical director of an area did not engage. GO8 said that sometimes it was like 'hitting their heads on a brickwall'. This highlights the frustration that some governance officers go through when consultants do not engage. The consultants are powerful and their lack of engagement could be a strong obstruction that prevents the smooth running of the governance agenda. Due to the differing priorities and the power of the consultants, this wall cannot be easily moved and it is difficult to progress past it.

While some governance officers felt that clinicians were unsympathetic towards governance, other governance officers were sympathetic and showed them empathy. GO3 reflected:

> *And they are difficult meetings at times and they can be full of aggressive clinicians, who have had a really long week and they don't want to be sitting in a 3-hr governance meeting, looking at incidents and stuff…*

Ensuring good governance is the mainstay of the governance officer's role. There would be tension between the two groups' differing priorities, but, ultimately, a united goal of providing good-quality patient care. Power dynamics play a part in ensuring accountability. Governance officers probably want the directorates that they support to be high performers and provide the best quality care to patients. Without support, authority, power or clinical knowledge, however, some governance officers could get frustrated, overwhelmed and uncomfortable while relating governance issues to consultants.

The consultant is independent and does not share responsibility with others, while the governance officer is dependent on clinicians for outcomes. The governance officer does not work alone; the participants reported that governance officers exist within a powerful dynamic network of relationships and high-level interactions with powerful members of the role-set as they strive to ensure accountability. The interests and expectations of the managers and clinicians and the types of interactions that take place influence the governance officer role and their ability to ensure accountability.

The network of relationships in which governance officers are involved exhibit explicit and implicit power (Dewar, 2000). The staff groups in the available literature worked within teams to bring about quality improvement. For instance, Gnani *et al* (2004) reported how governance officers attended a workshop and worked alongside GPs and nurses. Morrison *et al* (2018) also discussed how a quality improvement facilitator worked as part of a team to collate data for audits. Other staff groups exercise power in their own ways and self-interest is the force behind peoples' behaviour (Navarro, 2006).

Power dynamics are not only manifested in governance officer-clinician relationships. Although the participants did not mention any power tussles between consultants and senior managers in the interviews, they reported cases of conflict between consultants and matrons. Power dynamics between medical staff, especially, consultants with other professional groups, such as nurses, is well-documented (Hugman, 1991). It is intrinsic in an organisation such as the NHS for such power dynamics to occur. The participants talked positively about matrons and their attitude towards governance activity in the Trust. The nurses were reported as being more compliant with policies and guidelines than the doctors (Watson, 2005).

Consultants have long been acknowledged as having a lot of power and influence (Hugman, 1991; Spurgeon *et al*, 2015b). But within the consultant group, there are also different levels of power. Hugman (1991)

explains that power levels are defined based on the resources that are controlled. At the top, are the executive clinician-manager roles such as divisional medical directors and clinical directors who have executive management roles. They combine medical and leadership roles with their clinical duties and they are described by other clinicians as having crossed to the 'dark side'. This is because, although clinicians and managers have a common goal, they still differ on issues such as disbursement of the scarce resources, accountability methods and clinical autonomy.

Chapter 1 discussed how the clinician-manager roles were introduced by Griffiths (Griffiths, 1983). Spurgeon *et al* (2015a; 2015b; 2017); Spurgeon and Clarke (2017), while stressing that medical leadership improves performance, highlight that they are a means by which clinicians maintain and enhance their potential superiority and professional power to perform within healthcare organisations. Medical engagement is important, as it ensures that the key stakeholders are involved in decision-making (Spurgeon and Clarke, 2017). A lack of medical engagement was reported as one of the causes of clinical failings in the mid-Staffordshire Trust (Francis, 2013). Medical leadership helps to improve patient care, and as a result of this, a tool for measuring the engagement – the medical engagement scale (MES) – was developed. Sub-scales include Working in an Open Culture, Having Purpose and Direction, Feeling Valued and Empowered. The MES Scale would aid organisations in putting in place the necessary processes for doctors to

be recruited into leadership roles in order to enhance patient care (Spurgeon *et al*, 2011).

Some participants felt that there was a difference between surgeons and physicians.

> *I know there is a huge difference between the surgical side and medical side in terms of people. I've noticed that when I talk to some surgeons, the way they talk is a bit…rough! [laugh]*. – GO7.

As clinical governance seems to be embraced more by the physicians than by the surgeons, the participants working within the medical directorates enjoyed more cordial relationships and co-operation. The physicians are also said to be more approachable, compassionate and easier to relate with. GO2 reported that some time ago, surgeons were perceived as having a 'god-complex'. Surgeons have been described as strong-minded, strong-willed, confident and, sometimes, arrogant clinicians (Hughes, 2015; Walshe and Chambers, 2017). They were reported as acting in such a manner because they are trained to be strong leaders of their teams, especially, in operating theatres, where they could be subject to challenging situations.

Surgeons belong to the elite group of doctors and the power that they possess could be used in a positive manner to bring about conformity and ensure good governance within their directorates. There is no mention of issues such as clinician engagement or power dynamics among consultants in the available literature. However, some articles highlight

governance-related structures and responsibilities for the relevant staff (Peak *et al*, 2005; NHS Trust H, 2018; NHS Trust H, 2019b).

In Foucault's theory, power is an everyday phenomenon. It is everywhere. It is embedded at the micro-level within interactions, processes and relationships. Foucault argues that power exists in all forms of relationships and leads to resistance. Power is also fluid and it changes from one group to the other. For instance, as governance officers provide important information to their directorates, they can alter power relations – they indirectly have the ability to negotiate disciplinary power. The word 'governance', in Latin is 'Gubernare', which means steering or directing of a ship. It carries some element of power – a captain may command, but it is the crew who must implement. As power is everywhere and it does not necessarily flow from the top, the governance officer is not entirely devoid of power. All staff thrive on power and this has the potential of changing actions. Surveillance is enough to make some consultants co-operate with governance officers. In such situations, as argued by Foucault, power is positive, not negative.

6.3.6 Governance officers negotiating the power space

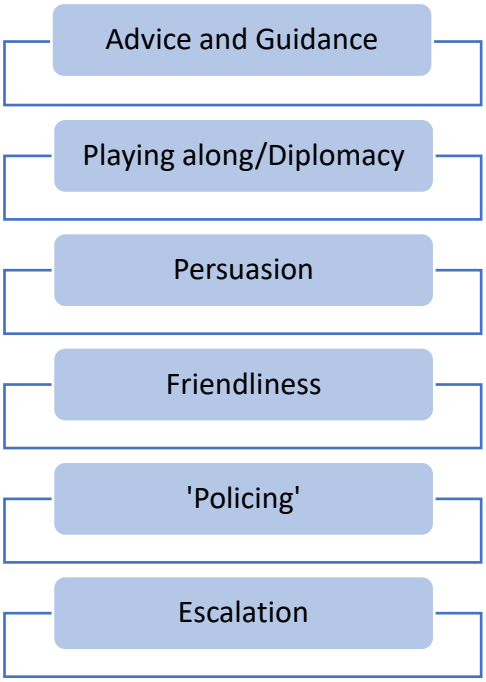
To achieve their goals, governance officers have to adopt various strategies. The effectiveness of the strategies they adopt depends on how they are received by the clinicians. It is noteworthy though, that some consultants were seen to be engaging, while others were not.

> *To be fair, there are some consultants that, erm, I liaise with that are very happy to talk to me and give me the information and they don't… I don't know whether they do see it as a burden, but they certainly don't come across like that*. – GO8.

Over time, the governance officers could gain the trust and confidence of the clinicians, resulting in stronger working relationships. The available literature did not explore any real-world strategies that are used by the governance officers/facilitators to carry out their roles.

The various strategies that were used by the governance officers to pursue the required outcomes from the clinicians are illustrated in Figure 9 and explained below:

Figure 9: Strategies used by governance officers to pursue outcomes



Advice and guidance:

Some participants discussed how governance officers advise and guide clinicians on governance-related issues. For instance, GO1 said that he advises staff on how to be compliant with policies and he prepares them ahead for meetings with the senior managers in order to minimise the level of scrutiny. GO1 reported that his approach is always well-received such that where ever he works, the clinicians that he works with want him to stay.

GO2 also talked about how she went on the wards to advise staff on incident-reporting. Such advisory and supportive roles were apparent in the available literature (Merrifield, 2005; Ward, 2009; Strachan *et al*, 2014; Morrison *et al*, 2018; NHS Trust H, 2018). The Clinical Audit and Quality Improvement strategy (NHS Trust H, 2019b) highlights 'support' of the clinical audit strategy as one of the tasks of the governance officer. The literature reported that the facilitators provided support with audit. Clinical governance facilitators were also described as providing support with the development of a patient satisfaction questionnaire at children's sleep and behavior clinic.

The level of support of this group of staff in the literature is higher than the support that was reported by the clinical governance officers. For instance, clinical governance officers were described as taking part in interviews and workshops (Gnani, 2004). Wall *et al* (2006) discussed how the clinical governance facilitators participated in a 2-day event to

improve patient outcomes in emergency care. Governance facilitators used facilitation techniques to gain ideas about patient journey, share ideas and put actions in place to improve patient outcomes. They also took part in multidisciplinary meetings where they were able to facilitate discussions on clinical governance. In addition, they coordinated Annual Health Checks (Brown, 2005; Cole and Radnor, 2010). Brown (2005) stated that she was accessible to staff and could speak on their behalf. This resonates with GO2's comment:

'*As soon as something goes wrong, I'm there. I'm a visible presence. I'm not someone at the end of the phone'*.

Such hands-on support would probably make it easier for the governance officers/facilitators to ensure accountability.

Other strategies discussed include advising. A governance officer reported giving advice to a clinical director whose directorate was falling behind with their audit plan. He was told off by the consultant as he was perceived as being rude. The case was escalated to the directorate manager who mediated and resolved issues. The second time, this governance officer advised another group of consultants regarding their audit plan. His advice was embraced and he was invited to join that team with a promotion as Governance Lead.

The approaches used by this governance officer show how outcomes vary depending on the audience. The approaches that were used by the governance officers seemed to be in line with their personalities. It could

be argued that the personalities of the governance officers play a part in the type of approach that they employ. The attitude demonstrated by a governance officer could possibly depend on their background, confidence, motivation, personality and their perception of the world around them. Behaviour that is considered as rude to a person might go unnoticed by another. This highlights once again, the variations in the *modus operandi* of the governance officers and the outcomes as they engage the clinicians in ensuring accountability.

Playing along/Diplomacy:

This was a strategy used when the expectations of the governance officers and the clinicians were not aligned and the clinicians were discouraging. The participants described how governance officers presented the wider picture, including the reasons and benefits of a request. By informing the clinicians that the request came from higher up in the hierarchy, GO1 made it more likely for the request to be carried out. This reduced friction between the governance officers and the clinicians, thereby strengthening their relationship and reducing stress.

Persuasion:

GO3 explained how he persuaded clinicians by studying the situation and agreeing to 'meet them halfway' with some tasks. This could include typing the information that is required and submitting it to the Division on behalf of the directorate. This approach involves performing the role of other members of staff. It reflects the grey area in the term,

'supporting'. When GO3 carries out tasks that are not under his remit, he expands his role boundary.

Friendliness:

Being pleasant and friendly was a strategy that enabled the governance officers to positively influence the clinicians. Some participants said that they were able to develop rapport and create bonds with the key persons in the directorates. Although this created a positive impact, as explained by some participants, it was important to be aware of which clinicians would appreciate such gestures. Part of building relationships meant knowing where to draw the line.

In the previous Findings Chapters, some participants described how governance officers were supportive and caring. These officers were described as 'nurturing' governance officers. They felt that they were accountable for the performance of the directorates, alongside the clinicians. They did not escalate issues relating to clinician non-engagement with their line managers, they took the responsibility upon themselves and carried out some of the tasks themselves. At other times, they ensured that the tasks were performed by the clinicians. In such cases, more strain was caused, especially where the clinicians were non-cooperative. This led to a situation of 'us' and 'them' in the clinician-governance officer relationship, which further highlighted the differences.

'Policing':

The findings revealed that some governance officers utilised a 'policing' approach. The participants reported that some governance officers leave the clinicians to take responsibility for their own performance by insisting that they complete tasks by themselves and be accountable. The perception that GO7 had about being a 'glorified messaging alert system' insinuates that he only passed messages on to directorates and he separated himself from the tasks.

GO7 acknowledged that having a 'policing' approach does not undermine his role and it probably shows that other governance officers take on tasks unnecessarily. Taking on of these additional tasks by governance officers to "cover" for non-compliant clinicians would have consequences for their own workload. The lack of consistency of approach could cause role ambiguity, role overload and role conflict. This could also mean that some directorates and consultants got more support than others and it shows inconsistency of approach by the governance officers as they carried out their role of ensuring local accountability. Quite importantly, the question of accountability also arises when someone has carried out a piece of work on behalf of another member of staff.

Escalation:

Where the clinicians were not co-operating, the governance officers resorted to escalating issues to their line managers or the directorate management team. Clinicians usually responded swiftly to the healthcare

governance managers' mails, to the annoyance of the governance officers. Although escalating issues to the healthcare governance managers passed the task of ensuring accountability to the managers, and reduced the governance officers' workload, it made some governance officers feel incompetent. Notwithstanding, some other governance officers would readily escalate issues. GO7 was happy with the strategy, however, he did not mention the impact this had on the clinicians. There is the possibility that he was not bothered if there was an impact.

6.3.7 Governance officers and the limits of micro power

This section is about the limits of compliance and the limits of formal and informal power of governance officers. The previous section showed that the participants had different ways of negotiating and persuading clinicians to perform necessary tasks. As advised by GO3, it was advantageous if governance officers were respectful and supportive towards the clinicians. The relationships that are formed by the governance officers are complex and the extent and limits of the support provided to the clinicians, therefore, is debatable.

Complex relationships generate negative and positive experiences. In this case, negative experiences occurred when the expectations of the directorates were different from those of the Governance Department. In addition, there could be a lack of interest which could cause tension.

For GO7:

> *It is frustrating. One of…one of them fell asleep! [laugh]. One of them fell asleep. Three of them started chatting away. None of them was paying attention. So, I am like, 'Why am I bothering with all this? I should just sit down'.*

Where there is a poor relationship, or a lack of clinician engagement, this hinders accountability and there is a tendency for the governance officers to be frustrated, as GO3 said:

> *Erm, the frustration comes, I think, when we struggle to get engagement from the clinical side of things. Whether it is due to them being too busy and too stretched to work with us or whether they don't [laugh] particularly get the governance thing. They don't want to engage with us. That is another matter entirely, but erm, it can be quite frustrating at times…* – GO3.

GO9 reported that the situations were made worse in directorates where the head of the team did not have an interest in governance and, therefore, did not show enthusiasm for governance. In such instances, the non-decision-making power of the clinicians was exposed. As the 'tone at the top' influences the behaviour of the team, there was a tendency for a lack of engagement and interest in governance to be passed down to other clinicians. This might be due to a strong relationship between the head of department and the other clinicians, where clinicians are motivated to follow the leader. A culture of nonchalance towards governance issues might be created within the team as a result.

In directorates where a governance officer is constantly replaced, the clinicians have to form new relationships with the new governance officers. This could cause issues with engagement. The new governance

officers will also be at a disadvantage, possibly, because they have not fully grasped how to manoeuvre between some of the clinicians. Some of them might be reluctant to engage meaningfully with the governance agenda to achieve a desired outcome. The clinicians might not engage with the governance officers, perhaps, because they know that the governance officers do not have the power to ensure accountability.

A larger number of negative reports than positive reports were made by the participants. Some would argue that this reflects on the general experience of governance officers. There were no instances, where the participants reported outwardly resisting negative aspects of their role with the managers. It would seem that the governance officers aspire to have relationships that are devoid of friction with those they interact with – their managers, the consultants and the senior managers. This might be because these members of staff are higher up in the hierarchy and are, therefore, more powerful.

The lack of engagement of some consultants with governance-related activity, and their preoccupation with patient care remains a major issue which caused role strain consistent with classic discussions (Goode, 1960). The situation might be changed with the younger generation of doctors. The General Medical Council's Outcomes for Graduates (2020) highlights the variety of standards for medical schools training doctors. Their role has changed and it now includes legal responsibilities, patient safety and quality improvement, leadership and team working, etc. In

Section 1, the junior doctors in the available literature were reported as being comfortable with the ambiguity of their role because of the training that they received in medical school. Role strain for the governance officers is intensified in situations where interactions are characterised by conflict and tension.

The dynamics within the NHS continues to alter the power structures and the hierarchy that are inherent in the manager-clinician relationships. This re-emphasises the fluid nature of power. This section has examined the nature of the accountability procedure as it relates to governance officers and the strategies that were used by the governance officers to ensure accountability. It has discussed governmentality as a form of disciplinary power. Key findings were that governance officers use a diverse range of accountability mechanisms. Power dynamics were also found to be an integral factor which influenced the ability of governance officers to ensure accountability. In addition, surveillance was identified as a part of the governance officer role. The next section discusses the perceptions of the participants in relation to their identity. The discussion is underpinned by Bourdieu's theory of habitus. The section also reviews the essence of a Community of Practice for governance officers.

Section 3

6.4 Issues of self and the dynamics of power

6.4.1 Introduction

This section uses the concepts of Bourdieu's theory of habitus to relate with the perceptions of the governance officers. It explains the different fields that the governance officers are in. It also looks at how the interactions that occur within these fields influence the identity of the governance officer. The section examines the way government officers think about their identity and how their sense of identity is influenced by their capital and habitus and how this affects their role. How culture and agency impact on the role of the governance officer is also discussed.

The section answers the research questions**:**

- How does the practical engagement of the governance officer affect their sense of self?
- How can the role of governance officers be conceptualised in terms of a Community of Practice within the wider landscape of NHS practice and accountability?

6.4.2 Identity, fields and power dynamics

McCall and Simmons (1978) argue that roles are developed as individuals seek to fulfil their goals. They define role identity as:

> *"the character and role that an individual devises for himself as an occupant of a particular social position."*

But the material in the Findings Chapter points to the more complex ways in which:

- The identity of the governance officer is influenced by their habitus
- The identity of the governance officer is a product of how they are treated
- The governance officer role and their identity are influenced by the network of interactions they experience.

To make sense of this, the literature review drew attention to Bourdieu's theory of habitus (1993) which explains how individuals operate within social fields. Bourdieu explains how the dynamics of societal power are influenced by the different types of capital that individuals bring into the social field.

Fields have been described in Chapter 2 as spaces of power. The level or position that the agent is in within a field correlates positively with the amount of capital they have which dictates how much power they will wield. The agents with the most capital are the powerful ones within the role-set. NHS staff bring varying amounts of cultural, economic, social and symbolic capital into the social field (Bourdieu, 1993). This is influenced by their backgrounds, levels of education, environments, ethnicities, etc. The varying amounts of capital are also sources of social inequality and they can influence social mobility.

For governance officers, the relevant social fields are the work environments in which they interact with the role-set, individually and

collectively, as illustrated in Figure 10. In these fields, the roles and power relationships are holding the governance officers and the role-set together. The nature of such fields is that they are dynamic and subject to change. Governance officers pivot between the clinicians, the managers and the other members of the role-set.

Figure 10: Position of governance officers in their social fields

The fields are discussed below:

Local Directorate Field:

This field comprises the governance officer and staff who work within the directorate that the governance officer supports. The staff include the clinical director, consultants, directorate manager, junior doctors,

matron, nurses, etc. Bourdieu (1993) suggests that individuals are placed in different levels or positions based on the amount of types of 'capital' that they have. The inequality in the role-set leads to power relationships and un-balanced interactions between the governance officer, the clinicians and managers, as explained earlier in Section 6.3.5.

The staff are placed at different levels due to the forms of capital that they possess, and the higher cultural capital of the consultants place them at a higher level within the field. The fields are characterised by domination, conflict and competition. They are based on recognition and prestige. The consultants and managers are higher up in the social fields because of their cultural and economic capital. The cultural capital of the consultants includes their formal academic qualifications and expert knowledge (Bourdieu, 1993).

Clinicians have an array of qualifications such as: Bachelor of Medicine (MBBS), etc., they are members of the British Medical Association, Royal Colleges; they have sworn to the Hippocratic Oath and they also have other miscellaneous qualifications to support their core degrees. Their movement up the social field aligns with Bourdieu's theory which suggests that a relationship exists between education and mobility. Within their field, the clinicians' positioning is further stratified based on those that have higher cultural and economic capital.

As discussed in Chapter 2, as agents then get acclimatised within the field, dispositions are developed and the roles and relationships are 'internalised' to form the habitus. The habitus of the consultants – their attitudes; the way they dress, their self-confidence, coupled with their decorum and good communication skills, place them further up on the social field. However, the attitude of some consultants – falling asleep during meetings and not engaging with governance officers, as described by participants, showed that behaviours may vary regardless of capital – status and education.

Governance Team Field:

Within H City NHS Trust, governance officers have a central governance body to which they belong. Other members of the Governance Department include the Head of Governance and Legal Services, healthcare governance managers, compliance managers and officers, and the administrative staff. The Governance Team field allows the members of the governance team to position themselves according to their capital. The field has two sub-fields:

– the Governance Officer Team Field

– the Central Governance Team Field.

Governance Officer Team Field:

In the Governance Officer Team Field, instructions are passed down and issues are escalated upwards to the Division. Discipline and surveillance are managed here as tools with which to stabilise the field.

The governance officers' agency is constrained by the environment in which they find themselves. In organisational theory, the power that is exerted by the hierarchy and the bureaucracy is also seen to reduce agency (Buchanan and Huczynski, 2017; Raffinsoe *et al*, 2019). In Bourdieu's terms, agents bring different items to a field and an agent's cultural capital, i.e., their behaviours, knowledge and skills are manifested via their habitus. Other factors influencing habitus are the culture of the organisation and the hierarchy of the agent. As Bourdieu explained, although subconsciously exercised, habitus is physically manifested in attitudes and this is shaped by the fields in which agents find themselves.

The governance officers operate from different levels within these fields and findings showed that their interactions with the role-set depended on the field in which they were. When an individual enters a field, the members of the role-set evaluate them and place them in a level that is appropriate to their capital and that of others in the field.

Although the governance officers are usually the first point of call for advice on governance-related issues in the directorates, reports of the

participants showed that they had relatively limited power and formal recognition. It is possible that their lack of clinical knowledge and not being in the frontline limits the power that the governance officers have. Governance officers are relatively new players in the field and this will impact on their sense of identity and how others identify with them. Governance officers do not belong to professional or regulatory associations where concerns, grievances and other job-related issues can be corporately addressed. There is no formal forum for advising on the role of the governance officer. Their limited formal recognition and the lack of professional status cause the governance officers to bring relatively less cultural, economic and social capital into the social field.

Governance officers in this study possessed different levels of academic training, none of which are directly related to the governance officer role. The variability in their academic backgrounds increases their diversity and may have reduced their unifying power. The governance officers, therefore, lack a professional identity within the NHS. It could be argued that the absence of a professional body to look after the affairs of the governance officer has placed a glass ceiling on their progress.

Habitus can evolve and GO1 discussed how training and experience had improved his satisfaction with his job. The training had adjusted his habitus to fit in with the conditions. The increase in knowledge and skills of the governance officer would possibly have enhanced his agency, his empowerment within the role and his ability to ensure accountability:

There were various issues when I first started. I hated the job. The first two or three months were really bad, I actually wanted to leave. I think all the training has helped. I think it is experience.
I think it is good – good for now, good for the future.
More skills... not just audit. I 'm becoming… It is better for my CV.

The findings, therefore, allow us to go beyond the available literature which does not refer to identity or the culture around the role of the governance officers/facilitators.

6.4.3 Conceptualising the role of the governance officer

We have seen that governance officers talked about ways in which they related with clinicians to ensure that governance requirements and targets were met in a timely manner. The variety of meetings that they held has been discussed earlier. The findings of the study too showed that, sometimes, there were conflicts within the role-sets. Some meetings with some of the clinicians were difficult because, as a governance officer reported, some of the clinicians were antagonistic towards governance-related issues.

… They rely on us for such a lot, but we are just taken for granted, for want of a better word. If things are not going according to plan, they say, 'Oh, it is Governance'. No, we are not appreciated – I don't think.

Another governance officer felt that consultants were an extremely busy group and as a result, they resented attending meetings. The constant following-up on clinicians for feedback on their performances could be due to the fact that obtaining feedback on local performance is essential

to the governance officers' role, providing feedback on performance is probably low in the priority of clinicians. This complicates issues for the governance officer.

The impact of the clinicians' lack of engagement is felt because of their powerful position within the role-set. Degeling *et al* (2006), in an early comparative study, described how some organisations encourage staff to strive to balance clinical autonomy with accountability and also to embrace power-sharing as a part of team-working. The governance officers/facilitators in the available literature were more 'hands-on' with their role. It is possible that if governance officers participate in specialist roles, this would make the governance officer role more valuable to the clinicians and encourage engagement. Where formal and informal relationships are strong between governance officers and the directorates, and the governance officer supports the team, the directorate will reciprocate and co-operate by responding to queries in a timely manner.

6.4.4 Culture and agency

Relationships within the field are affected by the wider culture of that field. In Chapter 2, culture was described as a set of shared beliefs, norms and values that define what is important and what is appropriate for individuals belonging to a group. Investigations following the Mid-

Staffordshire enquiry revealed that poor organisational culture was an important factor that influenced the quality of care (Francis, 2013).

Engaging in governance activity brings about a positive culture change and develops a culture where quality is at the heart of patient safety, treatment and care. Culture plays an important part in influencing accountability in the NHS (Maybin *et al*, 2011). The Trust's leadership has an important part to play in setting a positive organisational culture. Culture involves what 'we' do as a Trust, how we do it, the interactions we have with one another, what motivates staff, and rewards and punishments. It is reflected in whether as a Trust, there is a 'no-blame culture', whether the top executive communicates with the staff and shows commitment and whether the Trust is patient and quality-focussed. Culture is further reflected in the level of safety-consciousness, whether consultations are encouraged and whether the organisation embraces team-working.

The results revealed that the culture of the H City NHS Trust is dynamic – it changed from time to time within the operating environment. This also caused the role of the governance officer to change. The activities of the governance officers reflect the culture and norms of the Trust and this enables the Trust to run effectively. However, the local culture is also determined by external forces. For instance, when the Duty of Candour was introduced as a statutory law by Care Quality Commission (2008), staff had to be more open and honest with patients and/or their relatives

whenever the Trust had caused harm. This external change in culture ensures that clinicians are made accountable for their actions. It also passes some power onto the patients and their relatives, as they are given the opportunity to be involved in the investigations that take place. Being open and honest is best where there is a 'no blame' culture.

Governance also includes ensuring a positive culture that takes into consideration, respect, courtesy and active participation. This includes engaging doctors in management and leadership roles (Spurgeon *et al*, 2015a; 2015b). However, a patient safety culture might not always bring about improved patient outcomes (Sujan *et al*, 2019).

The prevailing culture in the Governance Department of H City NHS Trust was reported as such that some of the staff find it difficult to express themselves. For instance, GO6 said:

> *Some people want to talk in the meeting, you know – the team meetings, but they are frightened to, because if they say... They come back and say to me that they were frightened because if they say something, it might be taken the wrong way.*

A culture of fear, can mean, for instance, that clarification of certain issues would not be made possible, thereby leading to confusion, reduced confidence and knowledge. This could impact on the ability of the governance officers to ensure accountability amongst the clinicians.

Just as culture is dynamic, Foucault also argues that people do not have a solid identity; their identity is set by culture and it is created from the way people talk and think about things, i.e., the available discourse. For

instance, during the focus group, GO10 said that there had been a change in culture towards openness within the organisation:

> *I think it is the change in culture as well. It is more towards moving towards open and honesty. That is, becoming more…moving in the right direction, rather than the blame culture where people were willing to sweep things under the carpet if they did not want to be accountable, because of the consequences potentially. I am thinking the barriers are lifting a little bit, so it makes it easier to be…to get accountability.*

The aim of the governance team is to create a culture based on accountability and transparency. The nature of the role dictates this and, therefore, most information is easily accessible. The governance officers do this intuitively and this ability develops over time. Some participants talked about the good teamwork and communication amongst governance officers. They also spoke of the support provided by the team leaders and managers. These are attributes of positive culture that are important to meet the expected outcomes for healthcare provision. A positive culture potentially reduces the requirement for control, rules and regulations. Some will argue that culture is a terrain for domination, as the systems that are in place within the field are embedded in culture.

Although agency is dispersed (Raffinsoe *et al*, 2019) in a culture where staff are controlled, agency would be restricted for all staff, including governance officers (Buchanan and Huczynski, 2017). Governance officers have standard operating procedures that they follow. Staff, generally, do not always have the freedom to act independently, unless there is a good rationale. Notwithstanding, cultural identity is important

because it provides staff, including the governance officers with a sense of self and it also enables them to have better relationships with others.

Due to the relative late arrival of governance officers to the social field they have yet to establish their sense of professional identity. It is important to have professional identity, as this helps to avoid confusion. It has the potential of establishing role boundaries, thereby reducing role ambiguity, role overload and role conflict. This would lead to more effectiveness and efficiency, allowing the governance officers to be better positioned to ensure accountability. Where there is a lack of identity, the governance officers could possibly lack self-value and the confidence required to carry out their responsibilities.

6.4.5 The relational identities of the governance officer

6.4.5.1 Self-esteem of governance officers

Self-esteem is a sense of positive self-regard. A high self-esteem reflects a highly favourable view of a person's self. During the focus group, some participants claimed that because of their level in the hierarchy (Band 5), governance officers did not have adequate authority to have an effect on the activity of clinicians. They said that they were treated like junior staff by some consultants.

> *GO8: Sometimes, being a Band 5 as well, maybe, sometimes causes an issue…I'm not saying it does, but it could, because in liaising with the CDs, the matrons, the directorate managers, they are very, they are the top level. Erm, you only have so much...*
> *GO1: You don't have that authority.*
> *GO8: Yeah; as a Band 5.*

GO1: They see us as junior staff, sometimes.

GO8 was hesitant with the above response and this probably denotes a weakness, low self-esteem and self-confidence, and a feeling of being inferior. The perception was supported by other participants and this shows that it is a shared identity. The participants acknowledged that they bring less 'capital' into the field than the clinicians and the directorate managers. The statement also confirms that the governance officers' identity of themselves is poor and, therefore, they have limited power. It is possible that this could impact on their ability to effectively ensure accountability at the local level.

The disposition of the governance officers could also inform the attitude of some consultants, because they realise that governance officers have less cultural and social capital than themselves.

GO7 highlighted:

> A*nd their attitude towards GOs; it is demoralising and I don't think clinicians or any staff…people out there, they don't really get that. They don't really understand your attitude can affect someone else.* – GO7.

The above attitude of the consultants could be as a result of the way in which the governance officers portrayed themselves. This has negative effects as the attitude of the governance officers could hinder effective communication. It would further inhibit the governance officers from performing their role effectively. GO3 stated:

> *…but I think we are probably like a little bit unloved and undervalued by our directorates at times.*

The perception of GO3 strengthens the defensive identity of governance officers as not being of much value to the directorates. Such perceptions are demoralising and disempowering.

Governance officers and other staff who have similar responsibilities of ensuring good governance in NHS Trusts have different titles. The term, 'officer,' itself has a militaristic notion – which might also influence the way that governance officers are perceived and the attitude with which the clinicians relate to them.

GO7 explained how the attitude of some clinicians showed that they did not feel that he was important. They did not listen to him as he was presenting and such perceptions could have a negative impact on the attitude and identity of the governance officer. Another governance officer was also scornful in his perception of activities within the governance office.

It is important to note that not all the governance officers had negative feelings of low self-esteem and discouragement though. GO2 explained how proud she was to be a governance officer. She said that she was able to stand up to the clinicians, especially, when she knew that she was right. A similar view was put forward by Brown (2005), in the early days of the development of the role. She too felt positive about her role as a clinical governance facilitator. She felt that being a governance officer was rewarding, especially, as she was improving patient care. The

differing views of GO2 and the other participants shows that within a team, there are multiple perceptions. Likewise, not all consultants exhibited demoralising attitudes towards the governance officers. Those who exhibited such behaviour did so 'at times', as reported by GO3.

6.4.5.2 Governance officers' presentation of self

The literature review followed the classic sociological argument in suggesting that the identity of the self is influenced by society and this influences the behaviour of the individual (Burke and Stets, 2009; Mead *et al*, 2015). The findings show that the self-perceptions of the governance officers influenced the way in which they behaved – this had an indirect effect on the larger organisation, i.e., the Trust. Governance officers' views of themselves are influenced by their self-images or self-identities and also the relationships they have with the role-set. The constant role evolution could also lead to governance officers having an identity crisis due to limited stability.

In line with Mead *et al*'s (2015) concept of self and Goffman's (1969) impression theory, the governance officers could be described as actors. Both Mead and Goffman argued that, in a bid to create certain impressions about themselves, individuals become 'actors on the stage of life'. Governance officers are trained and expected to act in specific ways because of their roles. In their interactions, governance officers

tend to influence others' images of themselves and, thereby dictate how people relate to them.

Some participants, such as GO3, were motivated because of the value that they felt they were adding to patient care and patient journeys.

> *…Erm, but also quite enjoyable because, hopefully, you can see that your little bit of work that you are doing is hopefully making a difference towards quality and safety and the improvement of both of them. It is not always visible at first. It is not always tangible, but ultimately, if you are able to see the bigger picture and you know where your work is leading, it could be quite satisfying.*

Although GO3 said that he enjoyed his job, he talked of the perceived uncertainty around the effects of the governance officer role. He advised that it was not clear whether or not governance officers were making a difference; it was not always possible to measure quality improvement.

The participants used various metaphors to describe the ways in which they saw themselves and how they perceived that other members of staff saw them. These included:

1. Jack of all trades:

The governance officers felt that they were responsible for a lot of workstreams. They described the role of the governance officer as ambiguous, overloaded and characterised by conflict. The enormity of their workload could mean that the governance officers would not be able to master any of them. This could possibly affect their identity and reduce their power levels, as they are not totally sure of what actions to take.

2. Being on a battle field:

GO1 said that being a governance officer was like being on a battlefield, while another participant, GO8, said that being a governance officer was like losing a battle. This denotes the presence of an enemy. The participants might have felt so because of the hostile environment some of them found themselves in. At meetings, it was sometimes as if no one was listening. The clinicians might have felt that they are under constant scrutiny which they were not comfortable with.

2. Caught in the middle:

This metaphor was used by GO6 and it highlights the pivotal role of the governance officer. Governance officers described being caught between two powerful groups: clinicians and managers. They find themselves in the middle of these groups and act as messengers. This could also influence their identity. When discords fester or conflicts arise between the clinicians and the managers, governance officers could act as mediators between both groups.

6.4.6 Mutual support

Governance officers often met informally to discuss issues. This enabled them to share knowledge, develop relationships and solve issues together. They used informal methods of communicating, verbal and other written methods of communication, such as telephone conversations and e-mails. Such informal relationships are recognised to

be important in enhancing good relationships (Buchanan and Huczynski, 2017). These discussions were aimed at ensuring good governance by enhancing patient safety, improving patient treatment and care and reducing risks.

Some participants said that governance officers enjoyed being in a group, even though they did not always agree with one another.

GO4 said:

> *…so, what's important to me is that I've had good relationships with people here. Erm, and it makes the stressful times a bit easier, you know, when we are all pulling together. We've all got the same goals in mind. As I said, you spend far too much time at work to be miserable.*

Having good relationships at work was recognised by some participants as being important because the governance officers spent many hours together. Good work relationships and knowing that colleagues have similar experiences could possibly encourage mutual support. This enables them to solve problems and exchange ideas, thereby enhancing their ability to ensure accountability. However, GO2 and GO5 felt that team support was lacking.

> *There's only been three or four… and we've had to cover sick leave, erm, you know, maternity leave… just even had to pull together and then all I needed was an hour and a half to take, to go and do something extremely important …, 'Well, I'm not…' You know what I mean? You feel like you put your all in it and get nothing out* – GO2.

GO5 said:

> *…. I just want to say we don't work as a team. We are just told what to do like small children. They are the adults; we are the children and that's the attitude and it's very unprofessional.*

> *Somebody within the governance meeting should have put a complaint against certain individuals in the team, but I haven't got time to do that myself, because I'm not interested.* – GO5.
>
> *The head of governance works in her own little box. OK? She works in her own little box. The next tier of management work in their own little box and then GOs work in their own little box, yeah? This is not an integrated team. That's why I said, I've worked in better team networks than this…*– GO5.

They both voiced disappointment at not being supported by the team in a time of need, the mode of communication and the *modus operandi* of the subsets. Good team-working is important within groups (Buchanan and Huczynski, 2017). This absence of mutual support between members could potentially lead to low morale, reduced work commitment and reduced job satisfaction. This could affect the ability of the governance officers to ensure accountability locally. It could also possibly have a negative effect on the Community of Practice of the governance officers.

6.4.7 Summary of the chapter

The findings of the research study have been discussed using the lens of role theory, Foucault's theory of power and Bourdieu's theory of habitus. The findings were also addressed in relation to the literature review as discussed in Chapter 2.

Findings showed that the role of the governance officers which seemed quite obscure, is actually rather complex. In order to ensure accountability at the local level, governance officers have many associated roles and they must interact with numerous people who make

up their role-set. Governance officers experience role evolution, role ambiguity, role overload, role diversity and role conflict. The ability of governance officers to ensure accountability is influenced by the power exhibited by members of the role-set. The identity of the governance officers is influenced by the perception of the role-set. In addition, the identity of the governance officer affects their ability to ensure accountability. In the next and final chapter, the study is concluded and recommendations are discussed.

Chapter Seven

Conclusion and Recommendations

7.1 Introduction

This concluding chapter reviews the significance of the study and it highlights the original contribution of the study to the body of knowledge. The chapter also gives the implications of the study. The strengths and limitations of the study are provided and a discussion of how the results of the study will be disseminated and published is provided. The chapter ends with a summary which brings the thesis to a close.

7.2 Significance of the research study

The NHS is under great pressure to be accountable, not only because it is the largest institution of public expenditure in the UK, but also due to an austere financial environment. Over the years, the NHS has evolved and it has responded to changing social, political and economic climates. The role of the governance officer was introduced in response to a need for more accountability. This is important because accountability is key and comes with great consequences. Clinical pressures, including additional pressures presented by the COVID-19 pandemic, have led to a greater need for accountability.

The study has provided an opportunity to explore how governance officers play a part in improving patient treatment and care. It has explored the experiences of one specific group of governance officers and

how they structure accountability at the local level of the NHS. In addition, it has tried to give the governance officers a voice through which they have expressed their perceptions about their role and their experiences. The study has developed an understanding of how governance officers manipulate the space between the more powerful clinicians and managers in order to ensure accountability. This includes the tensions and challenges that they go through as they attempt to ensure accountability at the local level of the NHS. How power dynamics ensure accountability has also been explored. The study has led to insights into the identity of governance officers, their relationships and the network of the interactions that they experience within their role.

The governance officer role has evolved in response to changing times. This makes the role of the governance officers more ambiguous than that of most other staff groups in the NHS. That there is little information on governance officers is indicative of a lack of attention to governance; this, in itself, is a sign of marginality. If the governance officer role is to ensure accountability and there is some ambiguity around the role, or little is known about it, this could put effective governance at risk, leading to potential harm to patients. Governance in healthcare is important because it reduces risks to patient safety and minimises poor clinical outcomes. Governance officers are pivotal within the governance system and if their roles are ambiguous or their effectiveness is challenged by issues of power, then this has a potential impact on patient safety.

7.3 Summary of the thesis

The introductory chapter of the thesis discussed how, following a number of reported failings in healthcare, clinical governance was introduced to improve patient treatment and care. Governance officers were employed as custodians of clinical governance to administer the process of ensuring good governance, which includes ensuring compliance to local policies.

In Chapter 2, the available literature was reviewed using the integrative literature review method. This revealed limited information on governance officers, although additional literature was located about both the role of governance officers in different projects and how role ambiguity, overload etc., were not unique to governance officers. Relevant concepts and theories (accountability and governance) were also discussed.

The ways in which role theory might offer a framework to explore the role of governance officers were discussed. Role theory was extended with Foucault's theory of power, because power is an important factor influencing the role of the governance officer. Bourdieu's theory of habitus was seen to be particularly relevant in drawing out how the habitus of the governance officer impacts on their identity. The key findings from the literature review are that little is known about the role of governance officers and how they ensure accountability. However, there was some literature regarding their role in supporting quality

improvement projects, including hosting events, attending ward rounds and multidisciplinary meetings.

The literature review has shown that, within the NHS, governance officers/facilitators employ different approaches to move the governance agenda forward. Furthermore, other staff groups within the NHS experience role ambiguity, role overload and role conflict. There was no information on governance officers in the available literature with a theoretical underpinning.

The research questions were developed based on my interest in exploring the world of governance officers. The governance officers, situated between two powerful groups in the NHS – clinicians and managers, have a vital role in improving patient treatment and care. However, the available literature does not discuss the role of the governance officer in any detail, i.e., the practicalities around it, including the challenges and tensions that they experience as they ensure accountability.

Chapter 3 discussed the research design (phenomenology) and data collection methods that were employed to address the research questions. Individual interviews were carried out with eight participants and a focus group was organised for five participants. The chapter provided a description of the setting in which the study took place. This gave further insight into the complexity of the subject matter. My position as an insider researcher in this study was also acknowledged and

analysed. The chapter provided the basis for rigour, credibility and veracity, and it reviewed ethical issues relating to the study.

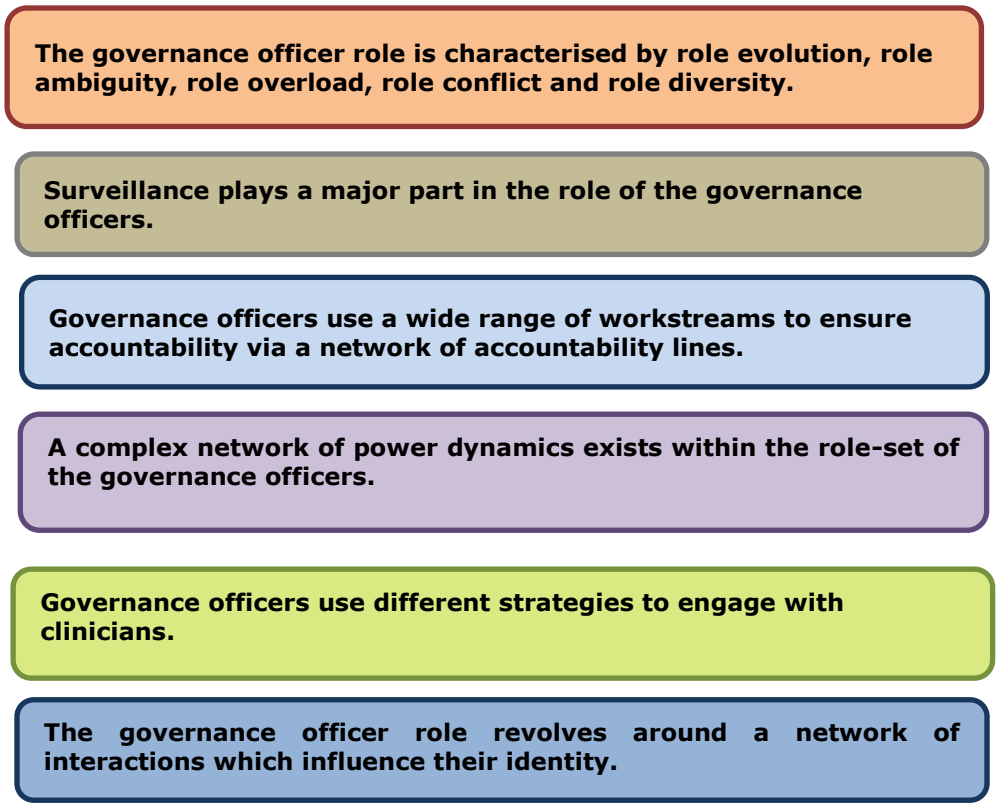
The data highlighting the perceptions of the participants about the role of the governance officer were analysed in Chapters 4 and 5 using Braun and Clarke's method of thematic analysis. The main themes for the individual interviews were: the governance officer role; pleasures and pain; unity despite diversity. The main themes for the focus group were: in pursuit of accountability; the dual role of the governance officer – policing and nurturing; self-perceptions and the perceptions of others; complex connections.

Chapter 6 discussed the findings of the study, interpreting them through the lens of a combination of role theory, Foucault's theory of power and Bourdieu's theory of habitus. The key findings of this study were that the governance officers experienced role evolution, role ambiguity, role overload, role conflict and role diversity. Surveillance was used as a mechanism with which to ensure accountability. Power was a major factor, influencing not only relationships and the ability of governance officers to ensure accountability, but also their identity.

7.4 Key findings and recommendations

The key contributions of the research study are illustrated in Figure 11 and they are explained below, alongside the recommendations.

Figure 11: Key findings of the research study



7.4.1 The governance officer role is characterised by role evolution, role ambiguity, role overload, role conflict and role diversity.

This section addressed:

Research Question 1: How do clinical governance officers narrate their role?

Research Question 2: What is it like to be a clinical governance officer within the UK NHS accountability framework?

Work-based role theory was seen as the basis for exploring how governance officers carry out their roles. As discussed in Chapter 2, workers need to role-play in a manner acceptable to their employer and themselves. An early insight of this theory by Linton (1936) is that a person's role is linked to structural positions and the self plays multiple roles within the confinement of these positions. However, role conflict occurs when the individual is expected to simultaneously act out multiple roles that carry contradictory expectations. This has been an issue with the role of the governance officer which has been described as ambiguous, overloaded and characterised by conflict.

A contribution that this study has made is to highlight the day-to-day dilemmas facing the governance officers – their role is characterised by role evolution, role ambiguity, role overload, role conflict and role diversity. The participants discussed how the role of the governance officers had evolved over time – from initiation to consolidation.

The explicit and implicit roles of governance officers have responded to changes in government policies, procedures and guidelines. They will continue to evolve according to the dictates of society and the political environment. The evolution of the governance officer role potentially led to role ambiguity, because as the role was always changing, there was a lack of clarity. This impacted negatively on the level of confidence of the governance officers and their ability to ensure accountability. The findings suggest that due to role ambiguity and role overload, governance officers

were, at times, unable to carry out their roles effectively and this potentially could lead to sub-optimal governance and accountability – ultimately impacting patient safety and outcomes.

There was a narrative of work pressure affecting the participants' role due to the wide range of the workstreams they do and how this affected their ability to ensure proper accountability. Apart from hindering effective accountability, role ambiguity, role conflict and role overload tend to reduce job satisfaction and increase role stress. During the focus group, the participants recommended that there should be no chasing for feedback on performance. In addition, the participants felt that there should be a centralised database for directorate performance and clinicians should have ownership of their responsibilities.

The participants also recommended that designated persons should be located within the directorates. There was a divergence of opinions on this issue. While some governance officers felt that having a central office would enhance productivity and cross-generate ideas, doubts were expressed by others who felt that it was better to have the offices of governance officers located within their respective directorates. The visibility of the governance officers within their directorates was considered as being paramount in ensuring that accountability is enhanced at the local level.

These are recommendations because some would say that governance officers are currently in place to mop up the inadequacies of clinicians – this should not be the case. Clinicians have a responsibility to provide quality treatment to their patients and they should be willing to take ownership of their responsibilities. Harmonious relationships between governance officers and the directorates are important. Where clinicians have ownership, this would free up governance officers and enable them to proactively undertake more productive tasks. If the above issues are not addressed, this could possibly lead to high turnover of governance officers, making it difficult to achieve organisational targets.

The study pointed to contradictions in some findings: some governance officers saw the role of the governance officer as an easy one, while other governance officers' views were that the role was challenging, with a heavy and diverse workload. There was some mention of role ambiguity, role overload, and role conflict in other staff groups in the NHS, as revealed in the literature review. The constantly evolving remit of the NHS probably leads to numerous new roles that take time to be consolidated and, in the interim, are subject to role evolution and role ambiguity. The findings confirmed that the governance officer roles were similar in the available literature and as described by the participants. Deeper research into the above role stressors will enable a better understanding of barriers influencing the role of the governance officer.

7.4.2. Surveillance plays a major part in the role of the governance officers.

This key finding was derived from Research Questions 1 and 2.

*Research Question 1**:** How do clinical governance officers narrate their role?*

Research Question 2: What is it like to be a clinical governance officer within the UK NHS accountability framework?

Surveillance formed an integral part of the governance officer role. Power is seen in the form of Trust policies, protocols and managerial decision-making (Raffinsoe *et al*, 2019). The study has acknowledged the importance of surveillance tools, such as audit, SUI actions and meetings, including governance meetings, quality assurance meetings and scrutiny meetings. These have strengthened the governance gaze. The findings revealed the complex network of interactions around the governance officers. There is a likely duplication of responsibilities within some meetings and the network of relationships. This research might be useful in assisting policymakers to streamline processes in order to efficiently enhance accountability.

7.4.3 Governance officers use a wide range of workstreams to ensure accountability via a network of accountability lines.

Research Question 3: How do clinical governance officers describe and experience accountability mechanisms in their local environments?

Limited prior knowledge was available regarding the diversity of the role of the governance officers and the impact of this on accountability. The notion of accountability has developed into a fundamental idea in

organisational behaviour and especially, in health services. Chapters 4 and 5 show how this agenda has developed in this group of governance officers and how governance officers relate to the idea of accountability as 'beginning with one party accepting delegated tasks and/or resources, reporting on the performance of the task or the use of the resources and being sanctioned for any failures.'

This study found that the governance officers that were investigated made use of a wide range of workstreams to ensure that clinicians were accountable – Clinical Audit, Shared Learning, External Visits, NICE Guidance Management, etc. There were many stakeholders, and accountability was ensured via a network of multiple accountability lines. The implications of this complex network could possibly be that some groups do not understand their roles and responsibilities. This could potentially cause role ambiguity, lack of clarity, confusion and the unnecessary duplication of resources and ineffective governance with subsequent consequences.

Governance officers strove to maintain good relationships within the directorates they work for, but there were some reported issues with some clinicians not engaging adequately with governance officers. This is discussed in more depth in the section below. Where the clinicians' performance fell below expectations, this was addressed at Divisional Governance meetings, scrutiny meetings or committee meetings.

The findings showed that the workload of the governance officer was influenced by the directorate they worked with – the governance officers who worked with the Medical Division had less work than those working in surgical areas. The governance officers had different ways of engaging with clinicians to ensure accountability. It is an important finding that all sorts of strategies had to be used to engage with the clinicians.

7.4.4 A complex network of power dynamics exists within the role-set of the governance officers.

Research Question 4: How do power dynamics influence accountability within the NHS?

Prior to this study, no literature had addressed how the complexities of power dynamics influenced the governance officer role. The participants talked about the power dynamics that exist within the role-set of the governance officer. As described by Hugman (1991), power dynamics was apparent at many levels within the clinician groups, i.e., between surgeons and physicians. Governance officers reported that they were sometimes stressed and frustrated because these powerful groups did not engage with them.

It was difficult for some governance officers to ensure that some of the consultants are accountable, because they are powerful and governance officers were lower in the hierarchy. The clinicians had more expertise and knowledge than governance officers who sometimes had to placate consultants for them to engage. This could lead to a possible compromise in ensuring accountability.

Although they were given on-the-job training, the lack of professionalisation – the process by which occupations acquire integrity and competence to enable them transform into professions – might explain why governance officers have different approaches to ensuring accountability. This lack of professionalism might also explain why there seems to be no boundaries to the governance officer role. The support of the managers is invaluable in enhancing performance and in overcoming some of the barriers that might arise. This would perhaps enable the governance officers to withstand the stress that they experience from time to time. Furthermore, the diverse qualifications and backgrounds of the governance officers means that robust training activities have to be in place to enable them carry out their roles efficiently and effectively.

This finding has implications for the role of the governance officer to be professionalised in order to enhance the quality of the role. It is important to regulate the outcome of the staff whose roles affect the health and wellbeing of the public. There should be regulation and conditions of professionalisation, i.e., stipulated qualifications for governance officers. This study could be extended to include hearing the voices of all staff working in the Governance Department. That is, to examine the perceptions, attitudes and responses of other members of the role-set in order to have an adequate account of the governance role process.

The finding also has implications for improved communication and enhanced consultations amongst all groups, including governance

officers, in order to diffuse tension. This would ensure that everyone's opinion has been sought and that all parties are aware of their expectations. This also has implications for effective management and training programmes, as role ambiguity would be minimised where effective management is in place and where managers are trained to clarify roles and redesign jobs, where necessary.

In addition, there are implications for further research into the stakeholders perspectives and also the views of consultants and managers on the role of governance officers. Future research could explore the power play between governance officers, consultants and senior managers within the NHS. Conflict areas between the clinicians and senior managers could be addressed so that the governance agenda is optimised.

7.4.5 Governance officers use different strategies to engage with clinicians.

Research Question 4: How do power dynamics influence accountability within the NHS?

For some governance officers, the role was easy, while other governance officers found the role challenging. Governance officers used different approaches to ensure accountability – 'policing', advising, playing along, friendliness and escalating in order to obtain the expected outcomes. Having different approaches for ensuring accountability might prevent the governance officer team from having uniform levels of accountability in the directorates.

The results reported that physicians were easier to work with than surgeons. This could potentially result in enhanced accountability, job satisfaction, employee morale and improved performance of the governance officers. These results also have some implications for the further training of the governance officers in order to provide the appropriate skills and enhance their competence on how to communicate with different personalities using appropriate levels of empathy. In addition, as part of their induction and training, clinicians need to understand how to engage effectively with the governance agenda. Further research could include exploring consultants' perceptions about the governance officer. This study will also impact on the occupational health and wellbeing and job satisfaction of the governance officer.

7.4.6 The governance officer role revolves around a network of interactions which influence their identity.

Research Question 5: How does the practical engagement of the clinical governance officer affect their sense of self?

The findings revealed that the identity of the governance officer was a product of how they were treated. Governance officers are assessed based on the amount of 'capital', in Bourdieu's sense, that they bring into the social field. This relatively new role is fairly low in the hierarchy of the NHS scale. It could be argued that the governance officer role is not regarded as important within the wider NHS framework. Also, the governance officer identity is influenced by the network of interactions.

The governance officers were seen as having different perceptions of their identity – Jack of all trades, junior staff, fighting a lost battle, etc. This has the potential to result in low self-esteem and conflict for governance officers. They receive little recognition from some members of the role-set. Governance officers are not considered a professional group and they do not have a profession. There is no institutionalised training or qualification specific to clinical governance that they have obtained. In addition, the governance officer role is not defined by a regulatory body or association, and governance officers, generally, have little sense of identity. This study has provided some thought-provoking insights into the identity of the governance officer which would have implications for their empowerment.

The study has identified how the governance officers' ability to ensure accountability is affected by their relationships with the managers and the consultants. It was highlighted that their role could be challenging and stressful, especially, when some consultants do not engage with them. In order to ensure maximum accountability at the local level, it is important that the governance officer is empowered. The study, therefore, has implications for recruitment, training and development of the governance officer. Issues influencing non-engagement of some consultants in governance activity should be explored. This will help to develop stronger and meaningful relationships between governance officers, clinicians and managers in the NHS.

7.4.7 A Community of Practice would enable governance officers to strengthen their identity.

*Research Question 6**:** How can the role of clinical governance officers be conceptualised in terms of a discrete Community of Practice within the wider landscape of NHS practice and accountability?*

A Community of Practice (discussed further in the next section) would be useful in empowering the governance officers and improving their identity. It could also be a catalyst that would enable the governance officers to be more efficient and effective. It would enable the governance officers to share their experiences and knowledge with one another. This is an effective method of dealing with stress and frustration caused by the job, as it will enhance the governance officers' ability to cope if difficult situations arise.

There is also scope for future research to identify what governance officers actually do and not what they say that they do. This would entail keeping a diary or carrying out an 'observational study' – participant observation. Another focus could be collecting data across a number of NHS Trusts. There is also potential for a research study of policies and how clinicians or governance officers perceive them.

7.5 Community of Practice

The results of the study show that governance officers are yet to build a collective sense of identity and agency. However, there is a need for them to do this, because how governance officers perceive their identities and how other people view them has an effect on how they ensure

accountability and their commitment towards this. Governance officers could build a sense of identity by developing a Community of Practice.

According to Wenger *et al* (2002), a Community of Practice is a group of people from the same practice, with a common interest who try to enhance their performance (Lave and Wenger, 1991; Wenger, 1998). Communities of Practice have been described as repositories of knowledge, where informal relations are made with the aim of improving learning and providing better access to knowledge. This is because the continual effort for quality improvement requires an environment that can be called a 'learning organisation' where shared learning can take place. True power is obtained by sharing knowledge which is generated and disseminated in a manner different from the traditional forms of learning. A positive impact from an efficient Community of Practice would be felt by individuals working within the team and local directorates. Forming a Community of Practice would help governance officers to address the issues around their identity. The steps towards having a strong Community of Practice for the governance officers include:

***Training*:**

Findings relating to the training of governance officers were obtained from the individual interviews. The participants reported that the role expectations of all staff were explained during induction and training sessions. Training plays a vital part in ensuring role consensus and conformity. Governance officers are equipped to enact their roles via

miscellaneous avenues of training, e.g., corporate training, on-the-job training and self-development. Although these brought about role consensus, findings also showed that the governance officers were divided in their perception of the quality of training that was received. Where training is not robust, it could possibly cause role ambiguity, role overload and role conflict.

According to GO1, there was so much to learn within a short pace of time and the onset of his role was a tough period.

> *It was like erm, walking into the deep end with no experience. It was difficult when I first started. Going to meetings with, erm, strangers, if you like, meeting strangers whom you have never worked with before, never seen. They are asking questions that you do not have an idea how to answer – not even finishing induction*.

GO6 felt that the governance officers underwent a steep learning curve. However, she felt that the depth of the training that was provided to the governance officers was inadequate for the responsibilities that they held.

> *So, we had to learn a lot in a short space of time. Erm, which was good, in the first instance, but erm, with a generalist knowledge, you have to know a little bit of everything. Erm, that's fine, but there's no depths in your knowledge – you can't specialise in anything. You only know a little about everything and with that knowledge, you are supposed to support your directorates.*

Some newly-employed governance officers claimed that their training was also substandard and inadequate. They felt that there was no robust training structure to come into and they felt unsupported in their new roles. This raises questions as to whether all the governance officers were robustly equipped for their role and whether they were effectively seeking accountability at the local level. From the above perceptions of the

participants on the role of governance officers, it is clear that an informal Community of Practice is developing. To move forward, the governance officers should enhance communication and relationship skills, which would include regular group interactions and constructive feedback sessions. This would enable them to have shared values and attitudes for an effective Community of Practice.

Data relating to the level of training was provided by some participants during the individual interviews. Training in the department has since been reviewed and this has brought about improved change. A more robust system of training is now in place in the Governance Department. There was no reference to training of governance officers/facilitators in the available literature.

7.6 Implications of the study

An understanding of the perceptions of governance officers assists in putting in place strategies that would enhance the delivery of the governance agenda and the quality of care that is provided to patients. This study may serve as a platform from which advancements in theory and practice for facilitating accountability at the local level in an NHS Trust can arise. At a local level, this study can directly benefit the organisation in which it took place. This is because the study is focussed on the group of governance officers based in this Trust.

More research should be done on the governance officer role with regards to gender, participant-observation and the views of consultants and managers. The study also has implications for future research with groups involved in pushing the governance agenda. Particularly, consideration could be given to the exploration of the role of other staff groups within the Governance Department (and the wider NHS Trust) in ensuring accountability at the local level. The findings of this research study should also be of interest to policymakers for future planning on governance-related roles and also other NHS staff groups. The results of the study could enable significant benefits to be achieved in order to improve the role of the governance officer.

7.7 Strengths and limitations of the study

7.7.1 Strengths

The suggested strengths of this study are:

***Originality*:**

This is the first research study to explore the relatively new role of governance officers. Before this study, no paper had explored the role of the governance officer using a theoretical framework. There is no other literature that engages with theory to explore the complex interplay of governance officers within the NHS organisation.

The study explores the governance officers' perceptions relating to their role, their experiences and values. It has filled a gap in the available

literature by providing detailed knowledge on the role of governance officers and how they ensure accountability at the local level of the NHS.

***Focus on roles and theory*:**

This study underpins the findings with three theories: role theory, Foucault's theory of power and Bourdieu's theory of habitus. It highlights their significance in the role of the governance officer. The study has also been used as a platform on which to extend existing knowledge around the role of the governance officer. This could have a potential local impact, as it provides useful information to policy makers in order to optimise the performance of governance officers. On a national level, the study could be useful to staff groups within other NHS Trusts in the UK. It would also be useful to health providers in other countries around the world, where staff are employed to ensure accountability at local levels. This would ultimately ensure patient safety and ensure the upliftment of global health.

***Qualitative rigour*:**

Rigour for the study was provided by maintaining credibility and trustworthiness. It was achieved by following the six stages of Braun and Clarke's framework for research synthesis. A well-defined search strategy was also in place to ensure rigour in the literature review and ensure that an accurate result is obtained. The evidence base was broadened by combining the data from the individual interviews and a focus group. This also ensured that limitations are minimised. Rigour and excellent

research quality were ensured through accuracy, integrity, honesty and transparency. Participant verification of transcripts and peer verification of the themes also enhanced rigour (Cooper, 1998; Whittemore and Knafl, 2005; Bowling, 2014).

***Emic perspective*:**

Another strength of the research study was that it was able to capitalise on its emic perspective. While recognising the doubts some have of the insider-emic approaches, the value of the approach here is that it has allowed the research to firstly, benefit from having a greater understanding of the governance officer role. Secondly, it has allowed the flow of social interaction and thirdly, it improved the intimacy between the participants and I while providing this body of knowledge.

7.7.2 Limitations

This study has a number of limitations.

Firstly, this is a one-centre study. The governance officers who were interviewed for the individual interviews and the focus group were all from the H City NHS Trust. Within this group, however, the sample was diverse in relation to age, ethnicity, qualification and experience.

Secondly, all limitations of semi-structured interviews and focus groups are acknowledged, including the questions that were asked and the prompts that were used.

Thirdly, the study was limited by my interpretive process, including my perspectives and my scope of knowledge and understanding. It was also limited by the relationship between the interviewers and myself. My being an insider researcher was a limitation as well as a strength, as there was some interference with my ability to be objective and not take important issues as normal. For instance, during the individual interviews, I was an insider, I was aware of the personality of a participant and, therefore, I was not taken aback by his responses. However, this may have influenced my perspective on responses that the participant gave.

Fourthly, the data for the individual interviews were collected relatively early in the research process. Hence, there was a 3-year gap between the individual interviews and the focus group. The governance officers who participated in the individual interviews were not all the same as those that took part in the focus group. Some of the governance officers had left the Trust. Two governance officers acknowledged that their stories would be different if I interviewed them again. Also, the participants who took part in the individual interviews and the focus group were all from one Trust. The perceptions of governance officers in other Trusts might have been different. The data might have been different if the same group of governance officers had been used for both individual interviews and the focus group, and also if the timeframe was different.

Finally, the analysis of power in relation to other specific characteristics was narrow. I did not analyse power in relation to issues such as gender,

ethnicity, qualifications, etc. The body of research will benefit from further research which looks into the impact of gender, ethnicity, qualifications, etc. on accountability.

7.8 Impact and dissemination of the research findings

The results of this study have been disseminated informally to some of my colleagues, individually and at team meetings. Information about the thesis was disseminated via Annual Progress Reviews and presentations at the university's Annual Research Conferences in 2019 and 2021, respectively. I shall disseminate the findings to governance officers and healthcare governance managers at team meetings. There are plans to publish the results of the thesis via appropriate journals, such as *International Journal of Healthcare Quality Assurance* and *Clinical Governance: an International Journal*.

7.9 Summary of the chapter

Patient healthcare is a vital and collective effort and governance officers play a significant part in ensuring high-quality treatment and care. It is crucially important that this invisible force is supported in their role. Although they are charged with growing a reputation of excellence, their role is characterised by challenges: role ambiguity, role overload, role diversity and role conflict. Still they work resiliently – carrying out a wide range of workstreams in order to ensure accountability.

Exploring the experiences of governance officers has revealed their tenacity. It has also meant looking at their shifting identities as they provide bespoke support to clinicians. This is impacted by the interactions that they are involved in. Governance officers have been employed for a worthy cause and they should, therefore, be unapologetic and proud custodians of the governance agenda. To ensure this, governance officers need to assertively own their role and, via a Community of Practice, build a strong identity within the Trust.

The research study has achieved its aim of addressing a gap in the existing literature on governance officers by exploring their perceptions on their roles and experiences. The study has described how governance officers ensure accountability at the local level of the NHS – through their as yet, unspoken and undocumented narratives. The study has also helped to understand the power dynamics that governance officers are involved in. In addition, it has highlighted how the identity of the governance officers is influenced by relevant others.

The role of the governance officer is important in ensuring accountability within the NHS. Governance officers play a significant part in enhancing patient safety, improving patient outcomes and ultimately improving the quality of patient treatment and care. It is more important now, during the COVID-19 pandemic, than ever before, to reinvigorate accountability at the local level of the NHS.

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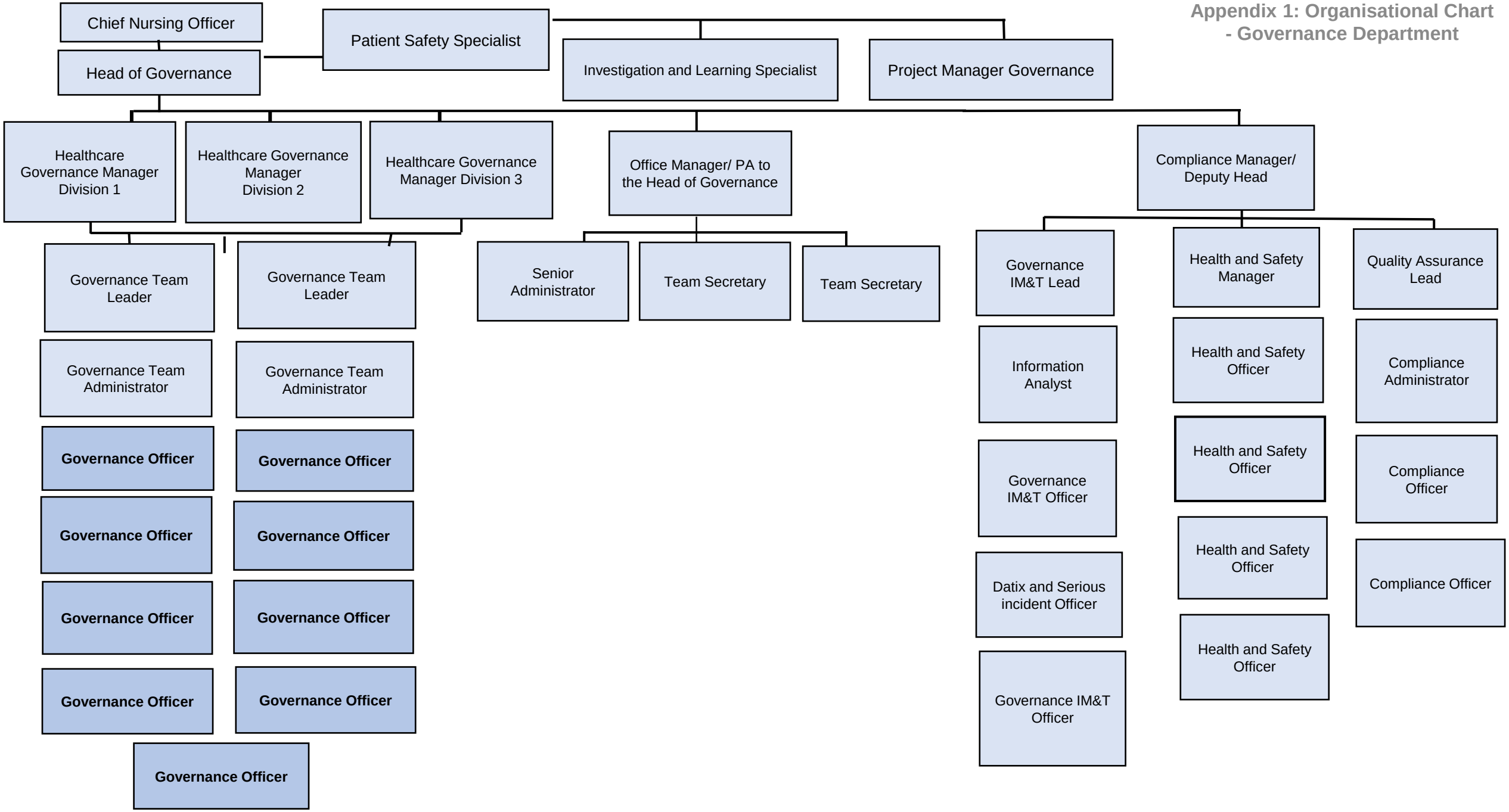
Appendix 1: Organisational Chart - Governance Department



[Trust logo redacted in Header – to ensure anonymity]

Appendix 2

JOB DESCRIPTION

1. Job Details	
Job Title:	Governance Officer
Band:	5
Salary:	£23'023 - £29'608
Reports to (Title):	Healthcare Governance Manager
Trust Website	Redacted
Directorate:	Corporate
Department/Ward:	Governance and Legal Services Department
JD Number:	Redacted

Text redacted

2. Job Summary

2.1 To work under direction, within the Governance and Legal Services function, to implement continuous quality improvement activities identified by the Healthcare Governance Department, Divisions and Directorates as part of the Trust Governance work programmes. 2.2 To actively contribute to directorate continuous quality improvement activities, through the implementation of activities policies and procedures to support the Trust with achieving compliance with national external accreditations e.g. NHSLA Risk Management, Care Quality Commission (CQC, Information Governance as directed by the Healthcare Governance Manager.

3. Main Duties & Responsibilities

To assist, facilitate, support and provide guidance to directorates in all areas of governance.

As directed by the Healthcare Governance Manager (Band 8a) and the Governance Support Team Leader (Band 6) to assist in delivering a work programme which enables directorates to undertake quality improvement activities following outcomes, all in line with trust strategies and policies, based on the following:

- Incident reporting
- Complaints
- Claims
- Inquests
- Risk management
- Compliance standards (including, Health & Safety, Information Governance, external accreditation standards)

To attend Directorate/Governance meetings as appropriate (as directed by the Healthcare Governance Manager).

To monitor the implementation of, and identify and escalate any areas of concern in relation to:

- NICE guidance
- External agency visits

To facilitate and progress report on delivery of governance work programmes and highlight any areas of concerns or issues in relation to the delivery of these to the Band 6.

To support the Directorates in the development and implementation of a rolling annual programme of prioritised audit which is linked to both local and national requirements. Including the provision of assistance, guidance and support related to the following areas:

- Audit methodologies
- Application of Trust approved audit protocols for audit design
- Data analysis and validation to facilitate audit/quality improvement project activity where appropriate, under the guidance of the audit lead

To act as lead on Trust wide audits.

To maintain key databases to assist with the delivery of the Governance agenda, including Datix, Clinical Audit Database, Performance Accelerator and SharePoint.

To facilitate the learning of lessons across the Trust.

To assist directorates with all aspects of data management relating to governance activities and accreditation systems. This may include data collation, database development and management, data manipulation, data presentation, report generation from existing systems.

In conjunction with the Compliance Unit to assist Directorates with the identification and collation of evidence for the following:

- NHSLA Risk Management Standards
- Care Quality Commission (CQC)
- Information Governance (IG), including Data Protection Act

- Health & Safety
- Any other areas of compliance.

To actively implement the communication plan, as set by the governance management.

To assist with any other activities, as required, to enhance the development of continuous quality improvement activities.

To plan and deliver specialist training in line with the requirements of OP41, in relation to the Governance and Risk Management agenda and maintain appropriate materials and literature for training purposes

To maintain an up to date knowledge of progress across all portfolio areas

Under direction from the Health & Safety Improvement Coordinator to assist the directorates with the reporting and monitoring of actions resulting from Health and Safety incidents/risk management activity.

To contribute to written reports and papers, as directed by the Governance Support Team Leader/Healthcare Governance Manager.

Governance Directorate Functions
To implement the office standards as set by the Healthcare Governance Manager including:

- Cover arrangements
- Templates
- Handling queries – etiquette etc.

To actively contribute to the setting standards of practice, behaviour and leadership commensurate with this level of post;

To maintain personal professional development and a record of learning and experiences

To maintain the standards and policies of the Trust

Professional
To maintain appropriate professional Codes of Conduct and standards where appropriate.

To maintain personal professional development and a record of professional learning and experiences.

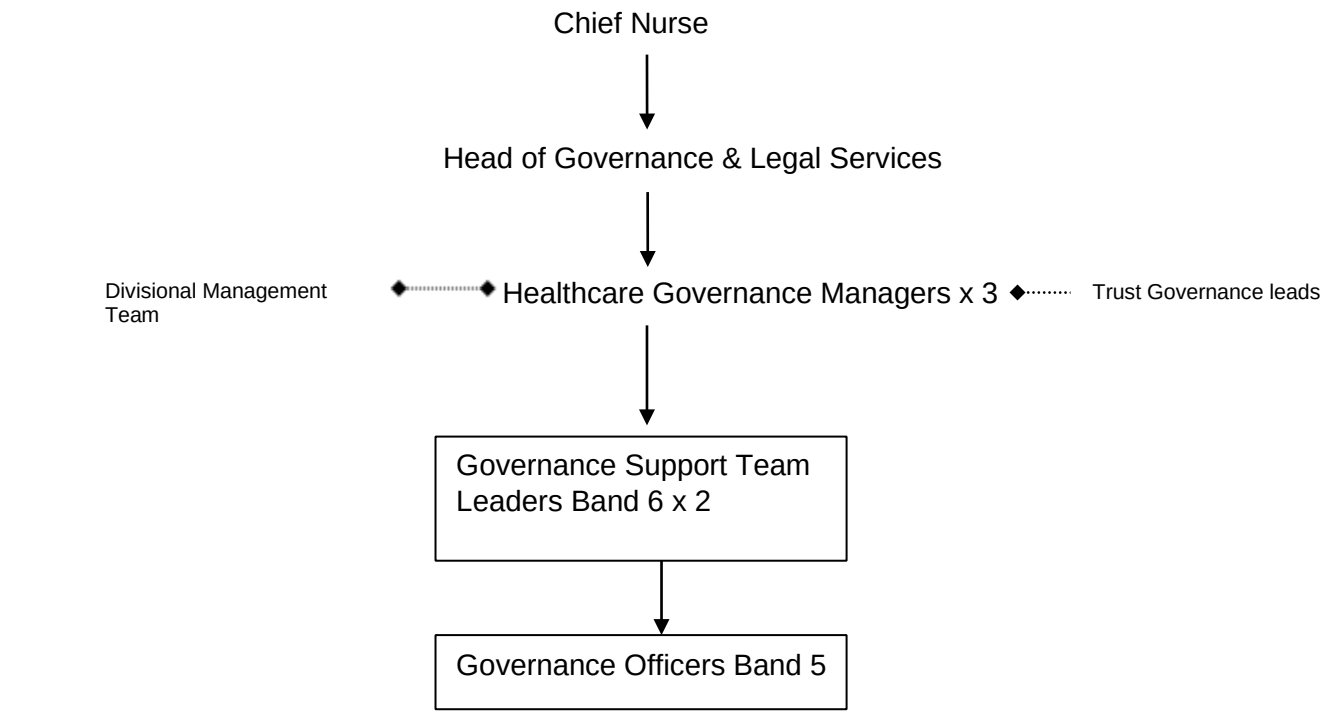
Maintain the standards and policies of the Trust, in particular those relating to patient confidentiality and data protection.

Liaison/Communication Support Functions
Develop and maintain strong working relationships to facilitate effective communication to support the activities of the Healthcare Governance Directorate, with the following staff groups/ teams:

- All members of the Governance & Legal Services Department
- Directorate Management Teams
- Directorate staff at all levels

This is not intended to be an exhaustive list of responsibilities but more an outline framework against which the post holder will be given flexibility to define the detail. Any changes will be the subject of consultation with the post holder.

4. Organisational Chart



This job description is not intended to be an exhaustive list of duties and it may be reviewed and altered in the light of changed service needs and developments after discussion with the post holder.

Infection Prevention

Maintain a current knowledge of infection prevention and control practices and policies through annual mandatory updates and role specific training.

Demonstrate a current knowledge of infection prevention and control practices through the delivery of clinical care and maintenance of a safe environment in accordance with infection prevention and control practices and policies. Take part in infection prevention initiatives in the local area. Challenge infection prevention practices, reporting breaches using relevant Trust policies as appropriate (e.g. incident reporting policy).

Equal Opportunities Policy
It is the aim of the Trust to ensure that no job application or employee receives less favourable treatment on grounds of sex, disability, age sexual orientation, race, colour, nationality or ethnic or national origins or is not placed at disadvantage by conditions or requirements which cannot be shown to be justifiable. To this end, the Trust has an Equal Opportunity Policy and it is for each employee to comply with and contribute to its success.

Health and Safety
Employees must be aware of the responsibilities placed on them under the Health and Safety at Work Act (1974), and associated legislation, to maintain a safe working environment for both staff and visitors, to observe obligations under organisational and departmental Health and Safety Policies, maintaining awareness of safe practices and assessment of risk.

Data Protection
If required to do so, to obtain, process and/or use information held on computerised or manual records in a fair and lawful way in line with the Data Protection Act 2000. To hold data only for specific purpose and not use or disclose it in any way incompatible with such purpose. To disclose data only to authorised persons or organisations, as instructed.

Customer Care
It is the aim of the hospital to provide patients and other service users with the best possible care and services. In order to meet this aim, all our staff are required at all times to put the patient and other service users first and do their utmost to meet their requests and needs courteously and efficiently. In order that staff understand the principles of customer care and the effects on their particular post and service, full training will be given.

Safeguarding
All employees have a responsibility to support the safety and well-being of children, young people and adults at risk of harm and to practice in accordance with legislation. Knowledge, skills and competency are to be maintained according to role and responsibilities in order to fulfil Safeguarding Children and Adults at Risk responsibilities. All employees are expected to comply with existing local Safeguarding policies and procedures, and Trust and [Text redacted] and Safeguarding Adults at Risk requirements.

Smoking Policy
The Trust provides a smoke-free work environment.

Confidentiality
The Trust is fully committed to encouraging its staff to freely contribute views on all aspects of health service activities, especially those on delivery of care and services to patients. However, you shall not, either during or after the end of your employment (however it is terminated), divulge to any unauthorised person confidential information relating to the Trust. This includes, but is not limited to, information covering patients, individual staff records, industrial relations, financial affairs, contract terms and prices or business forecasts.

Your obligations of confidentiality under this clause shall not prevent you from raising genuine concerns about healthcare, or a belief that criminal conduct, breach of a legal obligation, health and safety breaches or damage to the environment has been, is being, or is likely to be committed, or any information tending to show any of the above has been, is being, or is likely to be, deliberately concealed, provided that such disclosure is made in good faith and in accordance with the provisions

of the Public Interest Disclosure Act 1998 and the Trust's Policy on Raising Concerns at Work-Whistle Blowing Policy, a copy of which is available from the Human Resources Department.

Development

The Trust is committed to supporting the development of all staff. All employees have a responsibility to participate in regular appraisal with their manager and identify performance standards for the post. As part of the appraisal process employees have a joint responsibility with their line manager to identify any learning and development needs in order to meet the agreed performance standards required of the post holder.

NHS Constitution

The Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and the pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another.

All NHS Bodies private and third sector providers supplying NHS services are required by law to take account of this Constitution in their decisions and actions.

A handbook accompanying the constitution may be found by going to NHS Constitution for England - Publications - GOV.UK that essentially provides further and more detailed explanation of each of the rights and pledges.

Criminal Records

This post is subject to the Rehabilitation of Offenders Act (Exceptions Order) 1975 and as such it will be necessary for a submission for Disclosure to be made to the Disclosure and Barring Service to check for any previous criminal convictions.

PERSON SPECIFICATION

This document describes the qualities required for a post-holder that are not captured by the JD.

SPECIFICATION	DESCRIPTION
Qualifications *(This must include the level required to appoint to the post. Any requirement for registration should also be recorded here.*	Degree; or equivalent NVQ 4 in a relevant subject plus 2 years NHS experience; or: Professional Qualification
Experience/Skills *(Type and level of experience required to fulfil duties)*	Implementing Clinical Audit, risk management systems Good understanding of the principles of Clinical &/or Corporate Governance. Good understanding of healthcare and risk management accreditation systems Understanding of risk management processes and procedures Good understanding of quality improvement techniques- e.g. clinical audit, risk management, complaints Knowledge of Information Governance, Data Protection Act and Freedom of Information. Understanding of confidentiality. Ability to interpret frameworks for delivery of work programmes Ability to identify evidence of standard implementation and assess compliance Ability to assess the validity and suitability of evidence for accreditation inspections. Able to extract and use information from a variety of sources and formats. Able to predict trends by interpreting all relevant information. Able to make effective recommendations clearly indicating benefits. Identifies problems and suggests solutions or improvements. Identifies how different information interrelates. Requires standard keyboard skills Computer literate, including word processing and spreadsheets. Able to perform literature searches including from electronic sources. Has experience of using clinical information systems.

	Ability to facilitate changes in practice in collaboration with appropriate multi-disciplinary teams. Prioritises & plans work to meet deadlines and demonstrates an ability to implement decisions Ensures information is filed carefully and referenced. Manages time effectively, focusing on achieving priorities Displays a high standard of personal integrity Responds positively to constructive feedback Displays self-confidence and positive self-image Actively seeks ways to improve efficiency and effectiveness of own

	performance • Agrees clear objectives and targets • Has a strong sense of political awareness • Self-motivated, and able to work independently with minimal management
Communication Skills *(Indication type of communication and audience. e.g. face-to-face with patients, presentations to colleagues, etc.)*	• Communicates effectively with appropriate personnel. Information given correctly and accurately, and in a helpful and professional manner. • Able to make effective presentations to clinical groups in the organisation. • Drafts letters, memos, reports with clarity and awareness in a way that the reader understands. • Shows willingness and ability to listen. • Explains detailed complex information in a straightforward way. • Expresses opinions confidently and constructively. • Combines data from a variety of sources and compiles reports in accordance with reporting mechanism. • Able to encourage individuals to expand ideas using effective probing and absorb complex messages. • Able to collaborate successfully with multi-disciplinary teams. • Develops co-operative working relationships to gain commitment from others for quality initiatives.
Flexibility *(Note here any flexibilities required by the post. e.g. Shift Working required, New tasks may need to be undertaken frequently,)*	Ability to concentrate for long periods although be flexible and adaptable to changing workloads/priorities
Other *(Any other key issues not recorded elsewhere in JD or person spec.)*	

I understand and accept my accountabilities and responsibilities as outlined in this job description, person specification and KSF outline.

	Designation	Name	Signature	Date
Post Holder				

Appendix 3

Interview Schedule for Governance Officers

Project Title: Caught in the Middle: Hearing the Voices of Governance Officers in an NHS Trust

Participant Identifier: ……

Date: ……

Introduction: …….

Venue: ……

Sex: Male/Female

Age bracket: 20 – 25yrs

26 – 34yrs

35 – 45yrs

45 – 55yrs

>55yrs.

Qualifications: ……

Years of experience as a Governance Officer: …….

1. What motivated you to apply for the job as a Governance Officer?
2. How would you define the term, Clinical Governance?
3. How do you feel about the job?
4. What are your core values? How do they sit within the core values of the Trust?
5. What best experiences as a Governance Officer stand out and why? How did this make you feel?
6. What worst experiences come to mind? Why are they seen as such and how did this make you feel?
7. What are your views on Consultants as a group of staff within the NHS involved with the Governance Agenda?
8. What are your views on Senior Managers as a group of staff within the NHS involved with the Governance Agenda?
9. In what ways would you say you are given support to enable you carry out your duties effectively? From the Managers? From your colleagues? From outside the team?
10. Thank you for participating in the research project. Are there any other related issues you would like to discuss? Any thoughts or feelings?

Prompts

- Could you elaborate further, please?
- Could you please explain further?
- I do not quite understand what you are saying.

Appendix 4

Interview Schedule – Focus Group

Introduction:

Hello and welcome to the group. Thank them for taking time out to participate in the focus group and remind them of the purpose.

Duration: One hour**:**

- Three questions: 5 minutes each
- Three questions: 10 minutes each
- One question: 15 minutes

***The questions in italics are more like follow up questions**

A. Opening/Introductory questions: (5 minutes)

- **What is accountability?**
- *What do you understand by the term, 'Accountability' – with regard to the NHS?*
- *What are your views about accountability in the NHS?*
- Who are those responsible for ensuring accountability within the NHS?

B. Key questions:

Section 1 (5 minutes)

- **What role do you think Governance Officers play in ensuring accountability?**
- What are the various ways in which Governance Officers ensure accountability within the Trust?
- **What factors enhance Governance Officers' ability to ensure accountability?**
- **What factors inhibit Governance Officers' ability to ensure accountability?**

Section 2 (10 minutes)

**The study is also being undertaken to examine the power dynamics that is being played out by the staff groups.*

- **What is the influence of the power dynamics on accountability within the Trust?**

- **What are your views on ensuring accountability and creating tension within the Trust?**

Section 3 (10 minutes)

- **What do you think of the role of Governance Officer?**
- **How do you feel being a Governance Officer?**
- *How does the job make you feel?*
- What spurs you on as Governance Officers?

C. Ending questions: (5 minutes)

- **What should be done to enhance accountability within the Trust?**
- **If you could change one thing about the role of a Gov Officer, what it would be?**

D. Summary questions: (10 minutes)

*Can we summarize the key points of our discussion, please**? What key messages can we take away from this session?***

E. Final question: (5 minutes)

- **Is the above an adequate summary?**
- How well does this capture what has been said?

****Prompt questions:**

- Does anyone want to support what 'A' has just said? / Would anyone like to add to 'Bs' story?

- C, would you want to add to A's story?

- What is your opinion of...? How do others feel about this?

- I am not sure that I completely followed...

- Can you elaborate, please? /Tell us what you mean, please?

- Are there any other views on this? Who has a view that might be different?

- D, I do not want to miss out what you have to say. Would you like to say something?

**'If someone says, 'It was very interesting'. I could interject: 'Why was it interesting?'*

- *Thank them for their time and explain briefly what will happen following the session.*

Appendix 5

Date 20th April 2015

Taiwo Ahme
University of Wolverhampton
Faculty of Education, Health & Wellbeing

Dear Taiwo

Re: 'Caught in the Middle: Hearing the Voices of Governance Officers in an NHS Trust' submitted to The Faculty of Education, Health and Wellbeing Ethics Panel (Health Professions, Psychology, Social Work & Social Care)

The Faculty Ethics Panel (Health Professions, Psychology, Social Work & Social Care) has considered and reviewed your resubmission**.**

On review your Research Proposal was passed and the Panel believes that the ethical issues inherent in your study have been adequately considered and addressed. Therefore the Panel is giving you full ethical approval for your study (**Code 1 - Approved**). We would like to wish you every success with the project.

Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – Ethics Panel

D Chadwick
Dr. D. Chadwick PhD, MSc, BA (Hons). PGCE, CPSYCHOL.
Chair – Ethics Panel

[Logo, address and telephone numbers redacted to ensure anonymity]

26 May 2015

Mrs T J Ahme
Governance Officer
[Address redacted]

Dear Mrs Ahme

Research Project: Caught in the middle: Hearing the voices of Governance Officers in an NHS Trust

R&D Project No: 15SURV02

The above research project has been reviewed by the Trust through the Research & Development Directorate for R&D approval (NHS Permission).

All documents have been received including the approval letter from the main Research Ethics Committee and the Site Specific Information Form for the Trust. The clinical trial agreement/ service level agreement has been signed by the appropriate people within the Trust (as Sponsor) and by any sub-contractors.

Documents and Versions reviewed:

Document Name	Document Version	Date
Invitation Letter to Governance Officers (Appendix 2)	2	26 October 2014
Invitation Letter to Consultants (Appendix 3)	2	26 October 2014
Invitation Letter to Senior Managers (Appendix 4)	2	26 October 2014
Participant Information Sheet — Governance Officers (Appendix 5)	2	26 October 2014
Participant Information Sheet — Consultants (Appendix 6)	1	26 October 2014
Participant Information Sheet — Senior Managers (Appendix 7)	1	26 October 2014
Consent Form — participation in a recorded interview	1	21 October 2014
Protocol		03 November 2014

Trust (R&D) Approval has been granted for the project on the following basis:

1. Research Personnel Approved to Work on Project: Mrs TJ Ahme

[Footer redacted to ensure anonymity]

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2. Amendments: You are required to submit all amendments to the project, including the changed documents, notification of amendment form and regulatory approval letters (as applicable and once received) to the R&D Directorate for Trust approval. New versions of documentation can only be used once you have received notification from the R&D Directorate. As Sponsor for your project, you must notify the R&D Directorate through the Project Management Team, of required amendments before you submit to the regulatory authorities for review for the Trust to assess continued Sponsorship agreement.

3. Recruitment and Project Timelines — Please provide the R&D Directorate with the following information to ensure that the Trust is fully compliant with Research Governance and DOH reporting:

   a. The date of the Initiation Meeting
   b. The number of subjects recruited into this project when we contact you.
   c. When the project has closed to recruitment with final recruitment numbers
   d. When the project has finished.

4. Safety Reporting — Please notify the Research & Development Directorate of any SUSARs (Serious Unexpected Suspected Adverse Reactions) within 24 hours of you becoming aware of the event, by sending a copy of the report form to the attention of R&D Governance Team, Research & Development Directorate.

5. Dissemination of Research Findings: As with all NHS research, it is expected that the results of this study will be published in a reputable journal, may be presented at various meetings and will influence decisions on best practice. I would be very grateful if you could keep me informed of any publications, presentations and how the results of this research have been implemented into practice once the research has finished.

Sponsorship: You will receive a separate letter from the Trust through the R&D Directorate regarding the decision on Final Sponsorship Agreement and further ongoing project requirements.

The Research & Development Directorate will only consider to take on the role of Sponsor for your research under the DOH Research Governance Framework for Health & Social Care if you have returned a signed Delegation of Duties as Chief Investigator Statement that was sent to you upon first notification of project received

with the Research & Development Directorate. If you did not receive this to sign please contact the Project Management Team and a further copy will be provided to you.

On behalf of the Research & Development Directorate, I would like to wish you every success with your research project.

Best wishes.

Yours sincerely,

[Signature and names redacted]

Research and Development Manager

Appendix 7

Participant Information Sheet - Governance Officers

Researcher Name:

Study title

Caught in the Middle: Hearing the Voices of Governance Officers in an NHS Trust.

Introduction

An academic research project is currently being carried out on the experience of Governance Officers in an NHS Trust. This letter is to invite you to participate in the study. Before you decide to participate, it is important that you are informed of the purpose of the study and the level of your involvement in it. Please go through the following information on the sheet carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part. If you have any questions, or you would like to have some more information on the research project, please do not hesitate to contact me.

What is the purpose of the study?

Governance Officers support clinicians in a bid to achieve the goals set by the managers in the NHS. However, they are an invisible group within the NHS and their experience and perceptions as they negotiate the space between clinicians and senior managers have not been explored.

Why have I been chosen?

You have been chosen to participate in this exercise because this project is about Governance Officers. Your views and experiences are most important in establishing the context of the research.

Do I have to take part?

It is entirely up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without prejudice and without giving a reason. However, once data analysis has commenced any information you have provided up to that point may still be included anonymously.

What will happen if I decide to take part?

You will be asked to take part in an individual interview with me about your personal experience of being a Governance Officer; how you view your roles and the challenges you feel you face. In other words, what it is like to be a Governance Officer? You may also, be asked to take part in a focus group interview with other Governance Officers at a later point in the study.

What are the potential benefits and risks of taking part?

The findings of this proposed study could be valuable in laying the foundation for developing strategies to enhance delivery of the governance agenda. As the delivery of quality service and treatment within the NHS depends upon strong working relationship between those involved. Insights from Governance Officers could identify both challenges and elements of good practice within those relationships.

There are no risks to you in taking part outside of those you would experience in everyday life. However, by taking part, you may wish to raise issues that cause you discomfort or concern. If this occurs, you will be asked if you wish continue to participate in the interview. Any decision you make will be respected.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. The recording of your interview will be erased once transcribed and it will be stored on a password-protected computer in a locked office. Only the researcher working on the project will have access to the information. You will not be identifiable in any publication or report and all identifying information will be removed.

What will happen at the end of the research study?

At the end of the study, the findings will be analysed and written up in the form of a thesis. I anticipate that this will take approximately two years before the report is finished. This will be examined by my supervisors and an external examiner. Once I have finished my course, the thesis will be held in the Learning Centre at the University of Wolverhampton. I will publish a summarised account of my research in an appropriate professional journal.

What if I have a problem or concern?

If you have a concern about any aspect of this study, you could speak with me and I will do my best to answer your questions. Alternatively, you can contact one of my supervisors - Dr. Vinette Cross: V.Cross@wlv.ac.uk or Prof. Mike Haynes: m.j.haynes2@wlv.ac.uk

 Who has reviewed the study?

The study has been reviewed by University of Wolverhampton Research Ethics Committee, the Research Department, [Text redacted] and the National Institute for Health Research.

Contact for further information

You can contact me for further information by email: tj.ahme@wlv.ac.uk.

Thank you for reading this information.

October 2014

Appendix 8

CONSENT TO PARTICIPATE IN A RECORDED INTERVIEW

Title of project: Hearing the Voices of Governance Officers in an NHS Trust.

Please initial here

1. I confirm that I have read and understand the information sheet dated …….for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3. I understand that the researcher may wish to publish this study and any results found, for which I give my permission ☐

4. I agree for this interview to be recorded and for the information to be used for the purpose of this study. ☐

5. I agree that quotes from my interview can be used in the research report and any associated publications and understand these extracts will be anonymised. ☐

6. I agree to take part in the above study. ☐

……..	……..	……
Name	Date	Signature
……..	……..	……
Name of person taking consent	Date	Signature
…….	…….	……
Researcher	Date	Signature

Appendix 9

Taiwo Ahme
Postgraduate Research Student
Institute of Health Professions
Faculty of Education, Health and Wellbeing
MH Building
Wolverhampton
WV1 1DT

Date:

Dear…

I am a Governance Officer and also a doctoral student at the Institute of Health and Wellbeing, University of Wolverhampton. I am proposing to carry out a research project titled, 'Caught in the Middle: Hearing the Voices of Governance Officers in an NHS Trust'.

This letter is to invite you to participate in the study by taking part in an interview, and possibly a focus group interview with other Governance Officers at a later point in the study. The interview/s should last about an hour and would take place at a place and time convenient to you. Data collection will also include field observations. This will involve the maintenance of field notes that detail the behaviours and conversations of Governance Officers. This direct observation is aimed at understanding Governance Officers better, as they carry out their duties in their natural settings. Attached to this letter, is an information sheet that provides more information.

The proposed research study focuses on the experience of Governance Officers in [Text redacted]. The interviews are expected to provide an insight into the perceptions of Governance Officers and they are aimed at better understanding the nature of the experiences of these officers. It is hoped the study will be valuable in laying the foundation for developing strategies to enhance delivery of the governance agenda. Insights from Governance Officers could bring about an understanding of the intrinsic challenges that Governance Officers face within the NHS and identify elements of good practice.

Thank you for considering this request.

Yours sincerely,

T. J. Ahme.

Appendix 10

Participant Information Sheet - Governance Officers

Researcher Name:

Study title

Unresolved Tensions: Hearing the Voices of Governance Officers in an NHS Trust.

Introduction

As you might be aware, an academic research project is currently being carried out on the experience of Governance Officers. This letter is to invite you to further participate in the study by attending a focus group. Please go through the following information on the sheet carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part. If you have any questions, or you would like to have some more information on the focus group, please do not hesitate to contact me.

What is the purpose of the study?

Governance Officers support clinicians in a bid to achieve the goals set by the managers in the NHS. However, they are an invisible group within the NHS and their experience and perceptions as they negotiate the space between clinicians and senior managers have not been explored.

Why have I been chosen?

You have been chosen to participate in this exercise because this project is about Governance Officers. Your views and experiences are most important in establishing the context of the research.

Do I have to take part?

It is entirely up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part now, you are still free to withdraw at any time without prejudice and without giving a reason. However, once data analysis has commenced any information you have provided up to that point may still be included anonymously.

What will happen if I decide to take part?

You will be asked to take part in a focus group with other colleagues in which your views on how Governance Officers ensure accountability within their directorates, i.e., at a local level, will be explored. Your perception on the factors influencing accountability, including how you feel about your roles and the challenges you face while ensuring accountability will be explored. Essentially, the key questions of the focus group will focus on:

- Your perception of accountability within the NHS

- The role of Governance Officers in ensuring accountability
- Power dynamics within the Trust and accountability
- How to enhance accountability at directorate level

Will my taking part in the focus group be kept confidential?

All the information about your participation in this study will be kept confidential. The recording of the focus group will be erased once transcribed and it will be stored on a password-protected computer in a locked office. Only the researcher working on the project will have access to the information. You will not be identifiable in any publication or report and all identifying information will be removed.

What will happen at the end of the focus group?

At the end of the study, the findings will be analysed and written up in the form of a thesis. I anticipate that this will take approximately two years before the report is finished. This will be examined by my supervisors and an external examiner. Once I have finished my course, the thesis will be held in the Learning Centre at the University of Wolverhampton. I will publish a summarised account of my research in an appropriate professional journal.

What if I have a problem or concern?

If you have a concern about any aspect of this focus group, please contact me and I will do my best to answer your questions. Alternatively, you can contact one of my supervisors – Prof Rebecca Jester: R.Jester@wlv.ac.uk or Prof. Mike Haynes: M.J.Haynes2@wlv.ac.uk.

Who has reviewed the study?

The study has been reviewed by University of Wolverhampton Research Ethics Committee, the Research Department, [Text redacted] and the National Institute for Health Research.

Contact for further information

You can contact me for further information by email: T.J.Ahme@wlv.ac.uk

Thank you for reading this information.

October 2018.

Appendix 11

CONSENT TO PARTICIPATE IN A FOCUS GROUP

Title of project: Unresolved Tension: Hearing the Voices of Governance Officers in an NHS Trust.

Please initial here

1. I confirm that I have read and understand the information sheet dated …….for the focus group and I have had the opportunity to ask questions. ☐

2. I understand that my participation in the focus group interview is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3. I understand that the researcher may wish to publish this study and any results found, for which I give my permission ☐

4. I agree for this focus group to be recorded and for the information to be used for the purpose of this study. ☐

5. I agree that quotes from the session can be used in the research report and any associated publications and understand these extracts will be anonymised. ☐

6. I agree to take part in the above study. ☐

……..	……..	……
Name	Date	Signature
……..	……..	……
Name of person taking consent	Date	Signature
…….	…….	……
Researcher	Date	Signature

Appendix 12

Observational notes following the focus group

The essence of conducting the focus group was to capture data on how governance officers ensure accountability at a local level. Prior to carrying out the focus group, I conducted a pilot session which was arranged by my Director of Studies. The participants of the pilot session were my two supervisors and two PhD colleagues. The pilot session was useful because it:

- provided the confidence that I had earlier been lacking
- enabled me to curtail the number of questions to fit in to the 45-minute period for the main focus group
- enabled me to simplify the questions and avoid asking ambiguous and complicated questions that would confuse the participants
- enabled me to get used to the audio cassette for recording.

In the weeks leading to the focus group, I sought permission from my line manager for my colleagues to participate. Approval was delayed, as she said that we needed to have overall approval from the Head of Governance and Legal Services. This was later granted because the interview for the whole team would last just one hour. I my intention to carry out the session and requested their attendance. They all agreed to participate and I sent letters, participant information sheets and consent forms to them.

The focus group took place on 12th of November, 2018 in the Boardroom at 2:30pm. All the six governance officers that had been invited had accepted to participate. However, one of the governance officers had to take the day off work. The five governance officers that attended came in 5 minutes to the start time and I saw anxiety in their composure and a genuine desire to be of assistance.

On arrival, the governance officers sat along one length of the table, while I was on the adjacent side. I was conscious of the recording and I adjusted the positions of the recorders, so that all participants could be heard. I had three audio cassettes spread across the table: one from the university, one from the Trust and the third one was my personal recorder. I was hopeful that with these three recorders, I would be able to capture what was being said.

During the session, the participants seemed keen to discuss. They agreed and disagreed with one another. I had to draw some quiet members into the discussion and as the session progressed, the participants became more relaxed. The atmosphere was friendly and the participants were mostly in agreement with one another. However, GO4, stood out with some of his views - he still felt some tension. The participants said that they could understand why he felt differently. There were no hitches during the focus group and I was impressed with the level of interaction that took place.

The session lasted 45 minutes. I am apprehensive, but at the same time hoping that the responses of the governance officers will answer the questions of my research study, to a good extent. I felt that I should have asked more follow-up questions to enhance the discussions. I felt that, at the end of the session, the group had some difficulty in providing the key messages for the flip chart which was used at the end to summarise.

In hindsight, I should have spread the recorders further apart as, after recording, there were buzzing sounds in the background of two recorders, which might have originated from interference of the recorders, due to their close proximity to one another. This goes to confirm that recorders should not be fully relied upon and the importance of a note taker, which unfortunately I was not able to have. Thankfully, my personal recorder, a SONY Digital Dictation Machine, was clear and this was used to transcribe. After transcribing, there are some patches of unclarity that the governance officers were asked to clarify. I felt the focus

session was worthwhile and I was relieved that the recording was successful and a long-awaited task had been completed.

Appendix 13

[Governance Officer code redacted throughout - to ensure anonymity]

Interview Transcript Friday 6th May 2016, 4:15pm.

TJ: OK now! Welcome! Thank you very much for giving your time to participate in this interview. Like I've told you before now, this interview is strictly for academic purposes. It is part of a doctorate degree that I am undertaking at the University of Wolverhampton. Whatever information you provide today, will be strictly confidential and anonymised. I will transcribe this and the reason why it is recorded is because I cannot remember everything off head. So, once it is transcribed, the tape is going to be destroyed and all reference to your name will not be included in the transcript.

Erm, the interview itself should last about an hour, +/- a few minutes, depending on how much you have to say, really. If you want it to last two hours, two and a half hours… Feel free and just talk because this interview is mainly about hearing your story, knowing what your views are with regards to the role of a governance officer; the experiences you've had and just divulging what you think about being a governance officer.

Have you got any questions?

GO: No.

TJ: OK. We'll start now. Like I say, it's just about hearing your story.

GO: Yeah. That's fine.

TJ: Can you tell me your story then?

GO: My story?

TJ: Your story, yeah. What is it like being a governance officer?

GO: What is it like? Ah! What is it like being a governance officer? It's not bad! I find myself just being a walking reminder, more or less. That's really it.

TJ: A walking reminder of what?

GO: Just a reminder, for like my areas (my directorates) to do certain things. Or reminding them to do this or have they done that? ... just asking them questions and er, that's really it.

TJ: So, what do you remind them to do?

GO: I remind them to do anything governance-related, such as Duty of Candour, their Serious Untowards Incident actions, erm, their audits, how they are doing with the clinical audits. Erm and anything else that gets thrown at us to do – governance-related.

Because they don't do a lot - well, in my areas, they don't really do it inhouse. So, the way I see it (like in some areas, they have Governance Support Officers in their directorate and that's who the GO liaises with. But in my areas, since there isn't any of them (well there is going to be one in the future). But for now, I am liaising directly with the CD…the trio (the CD, Matron and the Group or Directorate Manager.

TJ: OK. Erm. What are your directorates now? What directorates do you work with as a GO?

[Text redacted]

TJ: You mentioned the Duty of Candour.

GO: Um.

TJ: What does that entail?

GO: Duty of Candour, to summarise, is basically, us apologising for something that happened to a patient that shouldn't have happened and caused them Moderate Harm.

And basically, in a nutshell: Patient comes in, they had an incident, it caused them Moderate harm. It was our fault, so we told them we are sorry. We were…write them a letter explaining it, explaining that we are sorry that it has happened and we are going to look into it, why it has happened, along with a phone call conversation, usually the phone call conversation and then the letter.
And then after the investigation is done, we apply Part 2 which is apologising again that it has happened, giving them the results, er…letting them know what actions have been put in place to stop it from happening again or reduce it happening again and that's really it. Now, it has become a legal requirement since the Francis Report.

TJ: You say 'we' and 'us'...

GO: 'We' and 'us'… I am talking in terms of the Trust.

TJ: OK. You mentioned the CD – What is the role of the CD?

GO: The Clinical Director…Their role is to…What? In terms of Governance?

TJ: Yes, in terms of Governance.

GO: The way I see it, the way I approach my Clinical Directors is: When something needs to get done, I just take it to them and they usually know, they usually respond to it or they'll tell me who to go to.

TJ: What group of clinicians are these CDs?

GO: Consultants.

TJ: They are consultants? You also mentioned the trio?

GO: Yes.

TJ: Who…What is the trio?

The trio comprises of a Clinical Director, who is usually a consultant (is always a consultant, actually) erm, a Directorate Mgr. or a Group Manager and a Matron.

TJ: What relationship do you have with the trio, as a Governance Officer?

GO: A good relationship with my trios. I think I have a good relationship with them.

TJ: What does it involve?

GO: What does it involve? Well, seeing as they are the point of contact for getting information that we need for our job, sometimes it's a hit and a miss.

Some of them are responsive, some of them aren't.

TJ: Um.

Involvement-wise, it's just everything like, governance-related that we have to do and we need a response.

TJ: You say some of them are responsive, some of them are not.

GO: Yes. In my areas, [[Text redacted].So, although he is approachable with the meeting at the first time, but when you try to get to reach him, outside of the meeting, it is very difficult or he is always busy or he never responds – so it is hard to get a response. So, when that happens, I usually go to the director, Clinical Director and try to get him to/them to respond and when that fails, I usually or almost always get a response from the matron. They are the most approachable from what I see. It usually works like that; if I don't get a response from one, I go to someone else, and if I don't hear from them, I go to someone else and if I don't hear from them, then I escalate it to my managers, which gets taken to Division. But it's funny that they don't respond to us, but once I take it to someone that is in a higher position to them, and then I get a response from them.

TJ: How does that make you feel?

GO: How does that make me feel? Well, I chuckle every time they respond. (laugh!) It's annoying. Because they…I don't know whether they know that we need this kind of information. Seeing as it has always been asked previously, and they know our role – well, I hope they do. It's frustrating. Because why going…Instead of going that roundabout way, why not just go through the person, get the response and it's done and dusted.

TJ: Um. How long have you been doing this job?

[Text redacted]

TJ: Would you think the degree you have is relevant or not to the job you are doing?

GO: Governance-wise, let's face it, no one really teaches Governance at university in a course – unless it is governance-related. But I learnt a lot about data quality and quality management, etc., etc. So, that part is applicable to the audit section here.

TJ: Um hm.

GO: So, yeah.

So, would you think a qualification is relevant for the job?

GO: Honestly, no. I don't really think so. However, I do note…I think why they ask for a qualification is because you are expected to produce a report and I think that's the main reason why they require a qualification. Because at university, you do reports left, right, centre.

TJ: Um.

GO: So, you've had the experience of doing reports. But I, honestly, don't think I needed a qualification - but the job description/the job specifications perhaps required you to have a qualification, even as a degree. So,…

TJ: What types of reports do you write?

[Text redacted

TJ: It must be an interesting erm…job, being a governance officer.

G: It…I won't lie: it is. Because, the main reason I think it is, is because, we are involved with the main people with the people in the directorate that are in the highest position in that directorate – so we get to hear a lot of things that we shouldn't hear or we wouldn't hear. So, it is interesting in that sense.

TJ: Would you think it's interesting in any other sense?

G: (laugh). In any other sense?

TJ: Apart from hearing what you are not supposed to hear?

GO: When I said it like that, I meant in terms of, you learn more about how the Trust is run, because they discuss things that you will not come across in Governance. That's what I meant.

TJ: Um.

GO: Erm, but data can be interesting, depends on how accurate it is, Erm, other than that, no…other than that, it's just a bog-standard office job to me.

TJ: OK. What experiences stand out as being, erm the most interesting experiences you have had?

G: The most interesting?

TJ: Have you got a specific example?

GO: No.

TJ: Or the best experience you've had so far as a GO.

GO: The best experience? Ah! I haven't had one yet. (laughs)

TJ: What's your normal day as a GO like?

GO: Normal day as a GO? Come in …check my e-mails and er…just do my work?

TJ: Which group of people normally write the e-mails to you and what sort of content?

GO: It is usually erm, either the consultants or nurses, so doctors and nurses basically.

TJ: What is the relationship between yourself and erm, these groups of people?

GO: I think it's positive. I get my responses back.

TJ: What is your worst experience so far?

GO: My worst experience was my first ever meeting with [Text redacted] Directorate. You see…I came into this job…when I was going through the Integrated Governance Report that we present in the Governance meetings, I was under the impression that everyone knew what that was and everyone knew why I presented it and everyone knew what I was going to tell them or they knew something about something. But when I was presenting it, I got a lot of blank faces! (laugh!) in that meeting. A lot of blank faces and I was a bit thrown off.

It was like, 'This was sent out a while back, you should have all seen it. Minutes have been made, the agenda has been made, did you not look at the agenda, etc., etc., etc.?' But then, it dawned onto me how Governance was from then… Governance was looked at or seen as from a clinician's or from a clinical perspective. And when you understand that that, then you understand why they were acting like that.

TJ: So now you understand how they look at Governance?

GO: Yeah.

TJ: How do they look at governance?

GO: Tick box!

TJ: Tick box?

GO: Tick box exercise.

TJ: How? How is that?

GO: Basically, we come to them with some work and they just simply see it as…they read it and if they do it, they'll just say, 'Yes, we do it'. That's a tick box. And we go away. They don't…I don't think they see the link between what we are asking for and patient's …patient care at the end. They don't see that link. They just see us as er…bureaucracy, I guess? You can say… they come with a suit and tie and we're asking them this and that and they're like 'Yeah, we do this! Yeah, we do this!' And then we go.

TJ: Um. So…

GO: I get asked time and time again, 'Is that everything we need to discuss, that we have to discuss?' - Everything we need to discuss, that we have to discuss…That last bit *we have to discuss* - meaning that they have to discuss this which has been told from 'high ups' in the policies and everything. So…yeah.

TJ: So, sitting there in front of the consultants with blank faces, how did that make you feel?

GO: Annoyed! (laugh) My other experience …I'll tell straightaway. They weren't paying attention. They didn't care. So, I felt like 'Why I am bothering telling all these guys?' And that meeting, that first meeting I had was the only meeting since then, from…except for the last meeting, where the turnout was high - meaning that all the consultants were present for the first time ever. And this only happened again recently in the last month.

Erm, well… Yeah, they were…they had blank faces. It is frustrating. One of…one of them fell asleep! (laugh). One of them fell asleep. Three of them started chatting away. None of them was paying attention. So, I am like, 'Why am I bothering with all this? I should just sit down. Why am I bothering presenting this?' But that was my first experience and then I realised from the Clinical Director, what he's like, and he's basically…I've learnt…I've learnt how to understand people more. Well, adult people more. I don't know how to say it without sounding rude (laugh). But older people because consultants are usually at the end of their career in that sense…

TJ: The peak.

GO: Yeah! The peak of their career, so they are usually pretty older (laugh). At the university, I never had that experience of talking to people who are experts in their fields and everything, but when it comes to doing something like this, they can totally mess it up. They wouldn't take any importance to it or anything like that. So, it was… it's a way of me learning these people and what they are like. And I've noticed that quite a few of them enjoy listening to themselves speak. So, when I figured that out, I thought, 'OK, I'd just give them. I'll give them all the information and they can say everything'. And since then, it has worked out fine.

TJ: Now that you have understood them and you understand how they work, how do you feel with regards to the way they see the role you are in?

GO: (laugh) I'll give you an example. One of my clinical directors…I had two Governance meetings. Well, one Governance meeting and then I had a pre-governance meeting with one of my other directorates. Separate directorates. So, when I told him this and I told him I just came from a Governance meeting, he was like…he was like…and his expression was like 'God! You've got two Governance meetings in one day! How do you it?' (laugh). So, that expression alone tells you what they see Governance as.

TJ: Um. Um. Um. Can you put that into words? The expression?

GO: The expression? Erm, they find it boring. They don't find it interesting. I know that for sure. They definitely find it boring and they are very unenthusiastic about it. I think that would…that sums it up: Boring; it's boring to them and they are very unenthusiastic.

TJ: Um.

GO: They are only doing it because either the policy states that you do it and as CD (Clinical Director), they have a role to enforce these policies within the directorate or it's in the contract. The big turnout that I mentioned earlier….That only happened because later on, I found out it's in the Consultants' contract. They have to attend so many (X) amount of meetings otherwise they will be erm…now, what's the word for it? I don't know, they get slapped on the hand or something.

TJ: Yeah. Their appraisal was coming up?

GO: Yeah, Their appraisal! Yeah. That's it.

TJ: They wanted to make up their quota, yeah? That's interesting. Very interesting. So, we have consultants on one hand – you've said that they find Governance boring and unenthusiastic. Would you feel that the

relationship they have with the policy-makers is affected in anyway as a result of this?

GO: It depends on what policies you are referring to, because some of them, they still have their own local policies for their directorates. I don't think for the Governance policy regarding them attending, making sure they have 10 meetings out of the 12 months or something. Erm, they'll abide to it. They won't object to it. I don't think it will make any difference. Erm, I don't think it will make any difference.

TJ: Um. How do you see consultants as a group of staff, on their own?

GO: On their own, they are…I'm trying to think of the best way to describe it. Each of these consultants are independent. Sometimes, there is a lack of communication. However, they are at the level where they can fix it quickly before anything happens So, I don't know how to say that and it hurts, basically.

I think that in terms of Governance, they don't care. That's the impression I get. They don't care. The one who cares is the Clinical Director. The one who is on top of it all, who will be responsible for everything at the end of the day. At the end of the day, someone has to be accountable for something.

TJ: Um.

GO: So, they are the only persons that would. Even though they know that the rest of the consultants won't engage, they have to engage.

TJ: Um hm. And carry it on, yeah? What do you like best about being a GO?

GO: I like how varied the job specification is. I'm doing…Like… we're doing the same thing over a week or so, but it's always doing something different and you're always asked to do something else, which is totally different as well, which is nice. It is nice because it changes up the pace, changes up the routine.

TJ: OK. And what don't you like about being a Governance Officer? Is there anything you don't like? Or is it all good?

GO: I think what I don't like about the job (which many people will probably agree) is the *repetiveness* of the job. But at the end of the day, you've got to maintain something you do.

TJ: Erm, I have had other interviews before now and some participants have mentioned that the job is stressful. It is demanding, it could be overwhelming…

GO: OK.

TJ: Would you agree with that?

GO: No. The reason why I don't agree. I don't know about other the GOs, other Governance Officers, but for me, when I first started, it was stressful because, Duty of Candour, never, did that before; SUI actions (Serious Untoward Incident actions) – never heard of that. All of these new courses and everything, I had to take it all in and it was a lot. Well, then, two months in, after getting used to the work and getting used to the routine, knowing what I have to ask for, knowing when what is due. I realised, 'Wait a minute! None of the work is actually coming down to me,' in the sense that the work that I have to ask for, is always the directorates' responsibility to respond. If they don't respond, I don't get an answer what more can I do. So, when I realised that, it's like, 'OK. If they are not going to respond, they are not going to respond. I'll just escalate it upwards. So I don't feel that pressure. I know that some Governance Officers feel like, if their directorates have done poorly, it's a reflection on them. But I don't see it like that and it only took me like two months to get me to that point and since then it's been a breeze, really.

TJ: So, it's a breeze now, working as a Governance Officer?

G: Yes. The only difficult part is…when you get to know your directorates and you got to know who to contact and everything for certain information, the only difficult part is that the person hasn't responded to you, but you know they will – that's the only difficult part – for me, personally.

TJ: I like the metaphor you used – you've said being a GO is a breeze. What other metaphors can you think of to describe your role as a GO?

GO: Glorified Messaging Alert System. (laugh).

TJ: That's Governance Officers or you?

GO: That's Governance Officer.

TJ: OK. That Glorified Messaging Alert System. OK. Why do you say so?

GO: Because that is what it feels like I ever do!

TJ: Um? You mentioned at the beginning that you were a 'walking reminder' and now you are a Glorified Messaging Alert System. That's interesting. How do you feel about that? The fact that you are a glorified messenger?

GO: It is a bit demoralising (smirk).

TJ: Why?

GO: (laugh). Well, it's not just that though…there are other factors involved as well. Such as peoples' erm, perspective or view of Governance: If they see the GO in a negative light, it demoralises us/well, me. Because, you know, I'm doing all this work and you are just going around saying, 'Oh! You know, push it aside, don't think it's important enough or what not.'

And their attitude towards GOs, it is demoralising and I don't think clinicians or any staff…people out there, they don't really get that. They don't really understand your attitude can affect someone else.

TJ: Um hm.

GO: Now, coming back to your question, 'How does that make me feel? I come to like it, but I don't think I'd like to stay as that for long. (smirk/laugh).

TJ: OK. What other jobs have you done – before being a GO?

[Text redacted].

Erm, another thing that intrigued me, was, in the job specification, it was telling me, it was saying that we will be in constant talk or meeting with the erm clinical directorates, etc., etc. Basically, the 'high ups' and I felt I knew back then what governance was like, not like how I know now, but I had a pic that not many people liked governance, from my previous job. And it came…Yeah. The only thing that intrigued me was that you are constantly talking to these erm top people in those areas and I think that's the main reason I applied for it - because I wanted to see how it's run from the top down.

TJ: Um hm and that has materialised, hasn't it?

GO: Yeah. It has! In terms of me learning how directorates are run. Like I'll give you an example: I was sitting in a Risk Register meeting with one of my group managers and he was…he was talking about one of the risks about [Text redacted]: the opening took him five years and that gave me the opportunity to ask, 'Why on earth would it take five years'? And he was explaining it all, how, basically, there's not enough money in [Text redacted . So, it wasn't funded or anything and he was explaining to me. I won't have picked any of that up if I was doing another kind of job not necessarily related to that. That's just an example, but there's more of that you learn about.

TJ: Thank you. Would you say your personality has enhanced your capability?

GO: I don't know. I don't know what kind of personality I have. I honestly, can't answer that.

TJ: OK.

GO: Try rephrasing the question. How…?

TJ: What kind of…You don't know what kind of personality you have?

GO: I don't know what kind of personality I have. I did do the PCM course, but…

TJ: OK. I'll ask, 'What are your values then?

GO: What are my values? My values…I think I am honest and my values are: I want to help people and obviously you can apply that to lots of things. But since I'm interested in science …in science subjects, in science field and particularly in medicine, and I thought, Hospitals? Why not? And being the NHS, their vision and em, what do they call it? I've forgotten, it was on an e-mail today. Their beliefs? I think it is. Do you know what I'm talking about or their values and something, I've forgotten.

TJ: Objectives?

GO: Yeah, values and objectives.

TJ: Trust objectives?

GO: Yeah. They are in line with what I believe in. I believe that people should have access to free health care. I believe that health care should be good quality. I believe that erm….yeah, those are the two main ones for me.

TJ: Um.

GO: Well, I notice that I am collecting a lot of data. [Text redacted]. Erm, I'm told I pick up on things that other people don't pick up on or don't think of. Erm, I raise issues - that sort which makes people talk about it. When I say people, I mean team leaders and then going on to healthcare governance managers and then they try to make something out of it. That's it.

TJ: OK. We talk about erm… Team leaders and healthcare governance managers. What's the team like? The governance officers team?

GO: I like I like the team leaders. I am not fond of the governance managers. Not as in, I'm, not fond of them as people…I think people-wise, they are fine. I am not fond of them how there is this bureaucracy in there, how there is this structure that has to be followed. I don't like that.

TJ: Can you clarify that?

GO: I'll give up an example. Er, there was an e-mail that got bounced around outside. Then it got involved with the healthcare manager, yeah? Instead of going …and it related to… the person who could answer it was the governance officer. Instead of just cc-ing the governance officer or sending it to the GO or anything like that, instead it was sent to the team leader. Team leader opened… I was next to the Team Leader cos I was talking about something. She opens it up, looks at the e-mail and says, 'Why are you sending this to me?' So then, all she does is just forward it on to the relevant GO.

Why go through that all when you could have just cc-ed him in and you would have got the response you wanted? My issue with the NHS, in this dept., in the NHS, in general, is inefficiency.

I get frustrated when I see the inefficiency. It's like you know, you know, when you have chalk. Chalk board, eh? And someone put that nail on a chalk board and that sound; some people can't stand it.

TJ: Um hm. That's how you feel?

GO: I feel like that. It really irritates me; it gets under my skin and I just feel…I feel like here it is inefficient, but it's getting better. But then again there is bureaucracy and there's dictatorship. They say they are open to suggestions. You mention them and then nothing comes out of it. An example is, we had meetings, the dept. meetings in the whole of Gov and Legal mtgs. Since the beginning, since I started and there's been actions on there that are still ongoing and every time that meeting happens which is once every two months or something, they keep (laugh) asking, 'Who is doing this? Who's doing that?' Again, that's inefficiency. Why not

just give it to someone who can do it and let them go do it? And get back whenever they can? But don't keep delaying it.
Keep going on saying 'Oh, we'll just leave it on to the next meeting. Then there's no point in the meeting, if it's just chasing up actions.

TJ: Um. Having said that, how do you see the team?

GO: The team is good. The team is strong. I like the team. It's a happy place.

TJ: Are you talking about the team of governance officers?

GO: Yeah.

TJ: …or the Governance Dept.

GO: No, no, no, the Governance Officers.

TJ: Governance Officers.

GO: There is friction between some areas; not… not GOs, well, some people within GOs team, but also within other Depts. such as compliance. Yeah, there is some friction there.

TJ: Why do you think so?

GO: You know, when you talk to people and you hear people talk. Or when you talk to them, it's like there is tension in the atmosphere and they are a bit snappy (laugh). And it's only towards you or anything Governance-related. It's a bit iffy but I think it's just drama.

TJ: Um. It could be. Do you receive support? What level of support do you receive?

GO: I don't …When I started, I had to do everything myself. There was no support. There was no structure for someone new to come in and learn from. You just had to sit with someone and understand it. Or you have to go away and read the policy – God knows how many times – to understand it. But let's face it, the policy isn't …You ain't going to remember everything in the policy.

TJ: Um.

GO: Policies are there to make sure something bad doesn't happen and to follow the good stuff. But a policy shouldn't be wordy, they should go straight to the point. And I find some of the policies I've read here, they are pretty wordy (laugh). And it's like, 'Why are you making me read all this? Why can't you just tell me the important parts of it? Or just show me which bits I'm supposed to learn instead of making me sit there and read all of the policy? I've never encountered them nor is it applicable for my area'.

TJ: Um.

GO: And er, what er, what was I mentioning people, policy, I've forgotten.

TJ: What other issues did you have when you first started?

GO: Oh yeah! Yeah! There was no structure when I first started like, 'I wasn't told about anything. I was shoved into the Duty of Candour and expected to know. That's the first impression I got. They were reassuring that 'Oh! It will take you time'. It was all very reassuring and everything, but at the end of the day, when I went to my first Governance mtg., I was there by myself. I'm spouting all this stuff to them and I don't even know the full story. So, it's like you are expecting me to go and tell them what you told me, when I don't fully understand what you told me. So, there's obviously, like a break in communication in there. So, I'm going there telling them a half story, they are asking me questions that I don't know the answer to. (laugh) So they end up getting half the story. I come back with another half of the story because I, at the end of the day, I'm really the middle man and I won't know exactly what is going through their heads and I won't know exactly what questions they'll ask or what their thought process is, so I'll always know half the story. So, I go back and repeat my half story and they end up asking me questions about that half story and I'm like, 'I don't know! That's what they told me, it's not my opinion or anything! (laugh). I'm just passing on a message here!' So, it was like that when I first started and it got annoying. So now, when they are making me… chasing and chasing about, I just tend to…, 'You know what, drop me an e-mail'. And I'll cc the relevant people in, so then, they just have the discussion and I'm cc-ed in for 'God knows why'.

TJ: Apart from the lack of structure, what other issues did you face when you came in? Are there any other issues or was it just a lack of structure?

GO: I think it was just a lack, cos there was no training.

[Text redacted]

There was a communication error. There's always a communication error.

TJ: Um. OK. Going forward, what suggestions can you make towards improving on the role of erm, the Governance Officer?

GO: I'm a firm believer in 'the more people you have in a room, the less likely anything will get done'. I believe the less people are in a room, the more efficient everyone is, the more work you'll get done. Therefore, I think, when you are doing these, when you go and when we have these governance meetings, instead of us like just going up there and explaining and everything to them blank faces, I think it's better if the CD, someone they look up to, someone who is basically their boss at the end of the day, explains it to them. But in order for that to happen, the CD or whoever, the 'high ups' are: Manager, Directorate Manager or Matron. But in order for them to explain it clearly, they need to understand it. So, I think it's more efficient if the GO meets with the trio or whoever at the mini meeting prior to the big meeting.

The consultants and the matrons, they say they are all busy. Fair enough, it's the clinical side, it is going to be busy and I'm all for them being out there treating the patients. I don't want to drag them away from that.

Erm, no one, from my experience, seeing all the blank faces, no one in the meetings ever goes in there reading the Minutes prior. So, you spend an hour… 30 minutes looking at the Minutes previously had. And everyone is and most of them are looking at it for most of the first time at that meeting. What's the point? That's my issue. What's the point of that? If they are not going to read the Minutes, then why do all that? Why spend so much time going through it. You can argue that you're refreshing their minds or retelling them that. How many times are you going to retell someone in order to get something? So, I feel like, we have a pre-Gov. mtg. where everything gets discussed; IGR and everything. The trio (whoever), they are, they understand what they have to talk about; they highlight what is important, what they have to relay back and they take it to the Governance mtg. and they relay back to them.

You can argue, yeah, that the Gov. Officer doesn't have to be there. But I think the GO has to be there, just in case they forget something or they are saying something and they don't really understand it – I'll be correcting them, etc. etc. But I find that more effective because at the end of the day, these Governance meetings it's not…these meetings aren't a mtg. for them to develop actions, to do something out of it. It is more of information…Our IGRs (Integrated Gov. Reports) is just

information. That's what it is…we are spending lots of time e-mailing information to them. In that sense, if it feels like that, why are GOs needed? We could just e-mail that to everyone. And they can, if they want information, they can read it, can't they? So, in that sense, no one, like I said, no one looks at the Minutes, so doing that, expecting them to read it, it's not going to happen. Hence why you have to deliver it to them in person. So, when you are delivering it to them in person, would they listen to you or would they listen to someone who is their boss? (Pause) Their boss! It would be more effective, I think. So, I feel like, if you went in that line…in that direction, it would be more effective. Erm, yeah, I honestly think, it's like the old school days. When we had assemblies, we all used to go – everyone, the whole clan, the whole school, used to sit there and listen to the Head teacher or what not talk. That's what it feels like! Just assembly! It's useful for them because they won't see everyone in the same room like that. They don't meet everyone, from whatever areas – because each directorate has different areas. They won't meet each other like that, so, it's good for them - so they use it. They use it and one of the consultants even said it one of my seniors: is to use these Gov. mtgs. as a way of erm, understanding what is going on in your directorate. So that is what happens towards…after all the Governance stuff is talked about. That's where the Ward Managers can get any concerns they've been having or the Directorate Manager or CD can get updates on what is going on within their directorates and that is more effective and more efficient, in my opinion. But in some case...It all depends on the actual trio that you get. Some of them are involved, some of…like the…erm…Clinical Directors. Some Clinical Directors are more involved, some of them just stay the hell away and expect you to do everything. So, it really depends on the people you have. But again, if you put it into the contract and you tell them they have to do it. They will do it! There's no ifs or buts, they will do it!

TJ: Um. Is there a difference between the directorates?

GO: Yes, there is a huge difference and again it's people. I know there is a huge difference between the surgical side and medical side in terms of people. I've noticed that when I talk to some surgeons, the way they talk is a bit …rough! (laugh) and it doesn't feel com…

Like, in my area, [Text redacted] they are more compassionate, or they can they talk more compassionately. On the surgical side, they argue more; they 'rage against the machine'.

TJ: You mentioned 'rough'. What's that? Can you expatiate some more?

GO: I think it's more to do with their role. They like complaining a lot, the surgeons – hence the 'rough' bit. So, I don't know, I can't really explain it,

because I don't have a lot of involvement with the surgeons, but I feel like they…, from what I hear from [Text redacted], they do like to complain a lot.

TJ: About what?

GO: About anything? (laugh). If there's anything they are not happy with, they will complain.

And I feel it is a total opposite of my areas. Like, they will do what they have to do. They won't put up a fight. They will at the beginning, but once you give it to them, then they'll realise, 'OK. Let's just do this, so they can stop talking to us'. And it's that. So, they just do it because they don't want us to get more involved or they don't want any hiccups, they just want you to go. Tick box!

TJ: Um hm. That's interesting. I think I've come to the end of all the….

GO: The end?! (laugh)

TJ: I have to talk about. Is there anything you want to talk about? Is there anything you want to tell me? You talk to me.

GO: I think…Actually I think…It's really come down to the NHS as a whole. The hospital is a huge organisation, huge organisations are going to have communication problems. Communication problems have always been one of the main reasons why something hasn't happened or an incident or what not. It always comes down to communication. Till they figure out or until they come to er, you know, resolve some of these communication…particularly between the 'higher ups', till then there's always gonna be incidents and this stuff. Cos we always take these RCAs (Root Cause Analysis) back, these RCAs back. These RCAs come from incidents that have happened and we are trying to figure out why they happened. Then they come back and then there's a summary. The summaries go to all the Clinical Directorates to talk about in their Governance meetings and to talk about any issues that apply to them and to make sure it never happens to them.

Why?…Now Division expects that to happen in the Governance meeting and 'Yes', it does happen. But when the turnout is poor or when many consultants are not there, that's actually… We do these procedures or what not. What's the point? And another thing…How much of what is going on in that meeting actually reaches the people in the directorate? Because not everyone attends, like I mentioned. It's always random. How much of that information goes back to the wards, goes back to the different areas? How much of it is being utilised? We don't know. And I honestly, think, when they ask us to take these RCAs and these incidents keep happening again and again, it just shows no one is, er, looking at the

Minutes (laugh). They don't look at the Minutes or they don't attend the Governance meetings at all. So, again, communication… what's going on there? Er, till the NHS resolves that, I think these incidents will continue to happen – there's always going to be a next one, unfortunately.

TJ: Thank you. Anything else to say?

GO: No. That's it!

TJ: OK. Thank you very much once again for your time. It is very much appreciated.

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Appendix 14 - Example of Initial Codes, Subthemes and Theme for Individual Interview		
Themes	**Initial Codes**	**Data Extracts**
Theme 1: The governance officer role	**Subtheme 1: The governance officer role - diverse tasks**	
The governance officer role	Various workstreams.	GO1: All the other work streams: Risk Management, Risk Assessments and all the others. All the other aspects of governance (pillars of Governance): Risk Management, Audit, Health and Safety and all the rest – all the work streams.
	Different types of workstreams.	GO2: Erm, for each of my directorates, I support them with Incidents, Risks, then Duty of Candour, SUI Actions. Erm, I lead on the Documentation Audit that all the medical students complete, erm, NICE Guidance, External Reviews, we sort out the paperwork for that, collate all the paperwork, Claims and Compensations.
	Governance officers are very busy.	GO4: At the moment: Yes - very busy.
	Constantly dealing with many different tasks at the same time.	GO2: With great difficulty. It is a constant juggling act.
	Variety of audits.	GO3: And our national audits and audits from risks, as well. We do it through a number of ways. Erm, one is through the prospective audits, where we monitor consent-taking, erm, DNAR.
	A variety of prospective audits were undertaken.	GO3: Erm, so we've got the prospective audits, which cover DNAR, Falls, erm, Consent, Transfer, ViEWS, (Escalation of Track and Trigger; when a patient is poorly and they reach a certain point where intervention is required and intervention from Critical Care to try and keep them out of Critical Care). Erm, Manual Handling (Patient Manual Handling). So, we monitor those with Prospective Audits.
	The governance officers have a heavy workload.	GO3: We've got work up to our eyeballs and we are stressed out.
	It is important to manage the workload efficiently.	GO2: I think it can be easy to get yourself lost. No, not lost…It can be easy to fall behind, if you are not careful. If you do not plan effectively…if you do not plan like the military [laugh], erm…you will lose it and people will suffer because of that. I think you have to be extremely clever in forward-planning, making sure everything is covered and letting…not letting each of your directorates down. But because of what we have to cover, the details and so many topics we have to cover, it cannot, but be quite challenging.

Themes	Initial Codes	Data Extracts
	Further activities undertaken by the governance officers.	GO7: I remind them to do anything governance-related, such as Duty of Candour, their Serious Untoward Incident Actions, erm, their Audits, how they are doing with the Clinical Audits. erm…and anything else that gets thrown at us to do; governance-related.
	Initially, the governance officers did not know about many of the workstreams.	GO6: ...prospective audits, doing clinical audits, NICE Guidance, which I didn't know anything about, erm, risk register – I didn't know anything about, incident-reporting, SUI actions, erm, Duty of Candour, which we had to recently learn, erm, external reviews, patient information, information governance, losses and compensation, etc.
	The role involves multitasking.	GO4: The phone will go and then suddenly you are dealing with some other query and then you're bouncing about databases and whatever, and then somebody in the office might just come and ask you a question, and then you are dealing with that query. Erm, and then you might be bouncing about databases for that. So, how many things am I working on at any one moment?
	Colleagues in the office felt sorry for governance officers due to their heavy workload.	GO6: I mean...so erm, one of them said to me this morning that, erm, they wanted to ...well, basically, that we were getting more work and they felt sorry for us. They are not governance officers; they are something completely different. They were saying that, 'I felt really sorry, cos I could see you are going to get more and more additional work because of the job'.
	Subtheme 2: The governance officer role - the evolving tasks	
	The governance department is finding better ways of doing things.	GO3: …how the department expects us to collect data and how to analyse it and how to record it. That's changed and it's ever-changing 'cos we're finding better ways of doing stuff or we are trying to do more things, but not add to the workload too much. So, we have to keep trying to streamline what we do and improve.
	Some managers and team leaders were new to the job.	GO1: Lack of understanding of the role, new managers, new team leaders, everyone was new to the job, new staff were coming in from outside…

Themes	Initial Codes	Data Extracts
	When the roles changed to general roles, the governance officers had to learn so much within a short period.	GO6: ...they decided to change our roles to a general role and of course, with that in mind, we had to learn very fast. So, erm, we had to learn a lot of workstreams which includes, erm…, Prospective Audits, doing Clinical Audits, NICE Guidance, which I didn't know anything about, erm, Risk Register – I didn't know anything about, Incidentreporting, SUI Actions, erm, Duty of Candour, which we had to recently learn, erm, External Reviews, Patient Information, Information Governance, Losses and Compensation, etc.
	More workstreams were being introduced.	GO6: The governance managers and the team leaders put more work on us. Because you can see! You can see...! OK. OK. For example, on the IGR report, there is something called IG Incidents. That's something new, isn't it? Information Governance incidents: So now, that wasn't there before! Now, we have this additional work to do. We have to monitor it to its conclusion. That's some more work.
	The role is still changing.	GO2: The actual role is still under review. I feel it is still under review. I do not think we have anything set in stone: what the GO role actually is just keeps changing and we tend to keep gaining areas rather than streamlining. That is my personal opinion. Hence Duty of Candour, SUI actions, all these changes, you know, it's extra stuff and when we have a review on what we do, we always tend to end up with more work than what we initially signed up for, so as a role, it is constantly changing – you can never say your role is this. Nothing ever stays still as a GO. There's always something moving through your door.
	The role of the governance officer has been improving.	GO1: The role of a GO when I first started was not as good, but it's better over the years.
	It was very challenging at the beginning.	GO1: It was like, erm…, walking into the deep end with no experience. It was difficult when I first started.
	Tougher over the years due to increased workload.	GO3: The workload has increased. We don't get any more time to do stuff in and we are very much held to account on timescales and deadlines. So, we've all found, I think. We've all found it a lot tougher in the last couple of years – in the way our roles have gradually developed and the work is increasing.
	The role has changed and is still changing.	GO2: Erm, now the roles have changed, because the last couple of years, there have been massive changes…. The actual role is still under review. I feel it is still under review. I do not think we have anything set in stone… when we have a review on what we do; we always tend to end up with more work than we initially signed up for.

Themes	Initial Codes	Data Extracts
	As the role was changing, the workload was increasing.	GO3: …We get more and more things they need to see; more detail on a monthly basis. You know, a new spreadsheet gets out. A new database or there is something else we've got to add to Health Assure. And that's not going to change, but it's just increased a lot over the last couple of years.
	Deadlines and tasks were increasing.	GO5: Erm, how the job has changed and the increasing demands. Erm, and it's also how you manage your, erm, daily tasks. Erm, what I am finding in my current role is that they keep putting more and more and more deadlines and more and more tasks onto us. They do not take anything from your every day jobs so you've got to put in the extra input to get, erm, you know, a good standard of output.
	Self- development.	GO6: Well, apart from the fact that they gave us a lot of, erm, training, I tried to, erm, read around as well – by reading the policy, OP10 [Operational Policy 10 – Risk Management Reporting and Patient Safety Policy]. I tried to do that…and a lot of it is just hands-on experience. You are just learning as you are going along. I think that we are still doing it, erm, now. Three or four years later, we are still doing it now, because the job is evolving.
	The role changes annually.	GO4: It is not the job that I was doing when I first started in 2012; was not the job I was doing in 2013 – things have changed; is not the job I was doing in 2014 – things changed, and in 2015, [last year], even as, you know, things have changed again, you know. We've been just recently asked to give our comments on changes to our role. So, you know, for me, the job keeps changing.
	Subtheme 3: Negotiating with all groups	
	GO1 has to be diplomatic and persuasive when interacting with some clinicians.	GO1: You have to, I think you have to be persuasive and erm…erm… What's the word? Let them realise it is important. It is not a waste of time. It is for their benefit. I have to be diplomatic when I tell them about such issues.
	Contacts include audit convenors and matrons.	GO6: The convenor is a very good person to work with and so I do get something out of that; having that relationship with him and seeing some progress being made – that I do enjoy. Erm, I now meet with the Matron and I do enjoy meeting her because I can see what's going on: she gives me the information that I need.

Themes	Initial Codes	Data Extracts
	Governance officers address the different elements of Duty of Candour, NICE guidance, QRV Visits.	GO8: Like Duty of Candour. We check erm on a weekly basis. There's two elements to that. Then we've got the Duty of Candour for SUIs, so that's another element of that. So you're checking those three. Then you've got all your SUI actions, you check that. Then you've got any NICE Guidelines that are outdated or that you are chasing. Erm, initial proformas or base-lines, erm. You make all those updates on the system, Health Assure. Then you're updating QRV visits. There are actions for those. Erm, or you are chasing people for those. You are doing, erm, audits. You are, constantly trying to find out where people are with their audits. Have they completed them? Have you got the reports? The presentations? Have the minutes come out?
	A wide variety of tasks - some were outside the governance officers' remit.	GO1: It's…We are asked to cover all these workstreams. I think we are all like 'Jack of all trades'. If you know what I mean… including being involved in things that are really not our area of expertise, e.g., Health and Safety, Fire risk assessments.
	Not a breeze!	GO6: No! It is not a breeze! Definitely not a breeze! I don't think...No! Absolutely not a breeze. A breeze means that you just ...you ... everything is 'honky doory' – everything is fine. Everything is nice and gentle. A breeze...? No, it's not! It's not a breeze. It's something that you just do with your eyes closed. I don't think that you can do this job with your eyes closed. Everything changes in terms of ...even if you do, like the Duty of Candour, you think, it's, OK, I'm doing this in one way and it's completely different. You have to use your mind.
	GO1 sometimes uses diplomacy when addressing the clinicians.	GO1: Well, when I pass those messages, I tell them it is not from me, not from Governance. It is from Trust Board, it's from external organisations. It is the law. It is Trust policy and we have to do these things.
	Governance officers use diplomacy.	GO1: Well, you have to be on their level, on their terms. Whilst it is trying to balance what's between my remit and what's not? I have to be diplomatic when I tell them about such issues: It's not from me or from the Governance. It's from higher up. Yeah. I don't make it sound like it is what I want. An example is Duty of Candour. It is not us asking. It is the law. That is a good example.

Themes	Initial Codes	Data Extracts
	Support system for governance officers.	GO4: But at least, I suppose, one of the things we have, in the governance office is a system where the managers, in a sense, are supporting us. Like… So, we have team leaders who are like the next layer along, and then there is an assistant healthcare governance manager and then there's two healthcare governance managers and beyond that there are people in the governance team [governance family] who give us support and backup. I should have mentioned that earlier as one of the positives of the role. The things that help you with the obstacles and help you with the challenges is this support network that we have.
	Consultants sometimes have pressing priorities that are more important than responding to governance officers.	GO3: You know, its way down their list of priorities. So I think we have to be mindful of that – just because our managers are telling us they need a response on something. Erm, it's not going to be the burning desire of the consultant to help you out in the next half an hour and give you what you want. So, then you have to look for ways around it, you know. That's why we send a lot of our urgent work by way of the directorate trio. You know, we've got a manager to speak to, if we are really desperate, we've got the Clinical Director and we've got Matron. And there are also managers and doctors under them that we need to approach. And we can do it. It's just that we don't always get the results when we want them and things can get a little bit tense.
	Governance officers interact with clinicians with different personalities.	GO2: Because there's that many personalities, different types of people and you've got to…it's not like you've got just one directorate…but they are huge areas and it is having that personality to try and get on with everybody.
	Different personalities.	GO3: I can't really say what's right or wrong 'cos you know, we've all got our different styles and you only know whether it's been successful or not.
	Sometimes, there are conflicts between governance officers and clinicians.	Erm, well, I was trying to be quite diplomatic with him and calm him down and tell him that I'm not aggressive. I'm not disrespectful. We are all aiming for the same goal ultimately, which is to see them complete their Audit Plan, which will make him look good in the eyes of Trust Mgt. Erm, and it would be positive for his directorate to complete their audits and get a good outcome from that. Erm, ultimately, I had to go and meet with the General Manager of his directorate, just to try and smooch things over. She was very nice and understanding. We talked through potential issues.
	Subtheme 4: Suggestions for enhancing the governance officer role	

Themes	Initial Codes	Data Extracts
	Governance officers should be involved only in tasks meant for governance officers.	GO1: I do not think we should be involved in these [Health and Safety and Fire risk assessments], if they already have dedicated staff who are experts in that area who can advise clinicians or staff on these areas.
	To have governance officers sitting in the directorates.	GO2: It could be improved if you had a governance officer per directorate. I really do think and having that time to sit with your directorates and move things forward. The only problem you've got with that is you could become isolated and don't learn anything from anybody else.
	Managers should communicate with consultants over developments in governance issues - not governance officers.	GO8: Erm, like we're the ones making the rules and sometimes I don't know whether we are the right people to set out the expectations, erm, because it is not seen…I don't mean that we are seen in a low position, but we are not managers and sometimes, I do feel like managerial input erm might help more than when there is only an issue and you escalate it. I think, sometimes, it could be done before then. So, when there's new policies or changes or something like that, I think, sometimes, it would be easier for it to come from a manager rather than us.
	To revisit how interviews for governance officers are done.	GO3: I think most staff have varying ability. I'm not trying to be mean to anybody, but I think to pick an interview with some careful questions and maybe a test of some kind, where the people are really optimistic, 'cos the job is challenging. It is not for everybody.

Appendix 15 - Example of Initial Codes, Subthemes and Theme for Focus Group		
Themes	**Initial Codes**	**Data Extracts**
Theme 1: Governance officers and accountability	**Subtheme 1: Perception of accountability**	
	Governance officers understanding - accountability means ownership.	GO3: Ownership.
	Governance officer's understanding - accountability means responsibility.	GO5: Responsibility
	Accountability means taking ownership for actions and omissions.	GO3: Ownership for the responsibility, really. Ownership for the actions. Ownership for omissions? *Pause* Erm…
	Accountability of governance officers is not explicit.	GO9: I think the NHS is too kind. It is clearly a professional accountability, which is, if you are a registered healthcare professional, you are a member of a profession which has a code of conduct and GMC, NMC or any other professional body. Then there is everybody else who has a different kind of possibly less explicit accountability which is where Governance Officers sit.
	Accountability involves providing assurance that policies are being adhered to.	GO1: Going out to governance meetings every month where we go through everything outstanding, and you know, any incidents ensure that they are following the policies, just advising them what they need to do.

	Accountability lies with the wards. It is the responsibility of the directorate to ensure that the staff are working according to policy.	GO2: Assurance that everyone out on the wards are working to policy and, like GO9 said, to doing their accountability. It is making sure that everyone is doing what they are supposed to be doing. GO2: I think sigh!…I'm answering this differently because I don't see myself as accountable. I see it as out there running their ward. They are accountable for their areas. I can advise, I can point to the right direction and do everything that it asked of me, but it is their responsibility to ensure that their staff are working as per policy. Erm, we, as I see it, look at the red flags and try to, you know do some actions to try and help ensure that …..Yeah, it causes tension and you feel. It is a personal feeling when you feel you have let…would you have done something different. To get a better outcome, how would you approach…Whereas, years ago, you feel as if you were responsible that your directorate not achieving what and I think yourself and myself going back a couple of years…and GO1.

	Subtheme 2: The role of the governance officer	
	Role of governance officers is to give advice/guidance/support. To ensure good rapport with the clinicians.	GO3: Giving them guidance, giving them advice and giving them support. Erm, nurturing them, building good rapport.
	Role of governance officers - auditing. Advising clinicians.	GO1: Auditing…Advising when they don't meet standards. Advising them if they ask for help.

	Governance officers play a role in ensuring internal and professional accountability.	GO9: I think we've got a limited role in professional accountability. Like SUIs, where they are clearly not meeting their professional accountability, then we are involved in that. There is an element of us being involved in holding them to account. I think this organisation is a bit different because organisational accountability in a Trust is sort of diverse. Because we are in theory, …are accountable to patients. We are also accountable to the CQC, to the Commissioners and there is an internal accountability as well, which is what I think our role, I think is… which is making sure the stuff that goes up the chain into committee meetings and Boards, for example. For example, a lot of the work we do is about that internal accountability, as well, i.e., up the chain.
	Providing information: Empowerment of Gov Offficers is made possible by the provision of robust information.	GO1: It helps if …because when I first started, we had a lot of tasks coming from managers or the team leaders. We were not told where the information feeds into or what it was for. So, we just passed the information on to the directorate without telling them or advising on what it is for. So, it was difficult for them to engage. But if you explain what it is for, and what the consequences are if you do not respond, then it helps.
	Being a governance officer is like fighting a loosing battle.	GO8: Sometimes, like you are fighting a losing battle, to be honest.
	Making a difference by ensuring safer practice for patients	GO10: Making a difference. Making safer practices for patients.
	Insufficient time to carry out all tasks.	GO1: You…There are things I would like to be doing, but I am not doing, like checking audit action plans.
	Tasks not thoroughly done, due to lack of time.	GO8: Yeah, as thoroughly as you could, to make sure…

	Working indepth is satisfying.	GO8: That's what you really enjoy. The, you know, when you are not just doing the bare minimum. You want to actually deep dive into somethings and you feel like you are really making a difference.
	No time to chase.	GO1: I haven't even been chasing as much as I used to in many things.
	No time to chase.	GO1: I haven't got time.

	No time to chase.	GO8: No, I was going to say that cos you haven't got time, though. Yeah.
	No time to chase.	GO1: To…like NICE guidance…if I don't get a response, I would chase and chase, but now, I only chase once.
	Divergence - one governance officer struggles with their job.	GO: I do struggle. I think partly because I came from …I suppose more because I worked in Community rather than Acute. So, I do find …To be honest, I find that the culture in the hospital quite confrontational compared to anywhere I ever worked. I actually, I think it's interesting that you should ask about tension because, yeah, I've never worked in places where you would have those conversations.
	Attending mtgs The role involves advising clinicians what to do. Incident management The role involves ensuring that the clinicians are following policies	GO8: Going out to governance meetings every month where we go through everything outstanding, and you know, any incidents ensure that they are following the policies, just advising them what they need to do.
	Importance of meetings	GO10: Attending where possible, the QIF meetings and various other meetings. Also, giving as much governance support as we can, given the time constraints.
	Role of governance officer includes attending meetings and guiding around governance issues.	GO1: Attending meetings…like non-governance meetings like Table tops or Audit meetings where you may have an influence. You are there to erm, guide them, to put them right if they are not doing something, you know, if you are not following policy, guidance or whatever.

	Accountability is made easier with Divisional support. Management of serious incidents and trends analysis Report writing - the reports that governance officers provide for the meeting enhance accountability Accountability is ensured by the setting up of action plans. Accountability is ensured at meetings, e.g, Performance Reviews.	GO2: Well, you've got your Integrated Governance Report which you send out and you table at your directorate governance meetings which escalate erm, serious incidents. You look at your trends, you look at the SUIs that you have within your departments, scrutinising the SUIs, erm, looking at the action plans, making sure the actions are not repeated the same as previously, because, obviously, if an action has failed before, it is not going to work a second time. Erm, it has helped now with the aid of the Performance Reviews where, erm, the Directorate Trio have to sit in front of Division and basically confirm their service against the five CQC domains. So, if then you know, their accountability and where they think they are. Erm, when we give our reports, that challenges. So, it is a good way to challenge the directorates. Where they might feel they may be Safe. Erm, they might be Good with Safe and Caring. And we can challenge that with some of the actions from the SUIs. So, erm, I think that it is a lot better and it has made a lot of difference, moving basically, to Plan B with the directorates being accountable for their own areas. Because moving to a few years ago, that was not the case and there has certainly been a big shift within the last 12 months, of that happening.
	Move away from a blame culture.	GO10: I think it is the change in culture as well. It is more towards moving towards open and honesty that is becoming more…moving in the right direction, rather than the blame culture where people were willing to sweep things under the carpet if they did not want to be accountable because of the consequences potentially. I am thinking of... the barriers are lifting a little bit, so it makes it easier to be …to get accountability.
	Helping the directorates to understanding that governance is part of their job.	GO1: Er, I think it's easier once the directorates fully understand that what you are doing is for patient care. Erm, they see their roles as very clinical and governance? Well, they are certainly used to seeing Governance as kind of an add-on. It is: 'This is being requested by Governance; we need to do this for Governance', 'Just get this documented for Governance.' And I think working with them and making them understand that it is not 'Governance'. It is not one department that is Governance, you know, it is it is part of their job.' I think it is their understanding that and that it is actually the asks come from higher than we are. It comes from the Commissioners or the Trust Boards or the Divisions. That makes it easier for them to work with you.
	Reflecting and being open to complaints/ being honest.	GO10: I think it's… er reflection, reflecting, erm, being responsive to complaints, and listening, erm, about being open and honesty, erm…

	Adequately communicating information to the clinicians: Empowerment of governance officers is made possible by the provision of robust information.	GO1: It helps if …because when I first started, we had a lot of tasks coming from managers or the team leaders. We were not told where the information feeds into or what it was for. So, we just passed the information on to the directorate without telling them or advising on what it is for. So, it was difficult for them to engage. But if you explain what it is for, and what the consequences are if you do not respond, then it helps.
	Subtheme 3: Changing nature of the governance officer role	
	The governance officer role is a lot easier now.	GO5: It is a lot easier than when I first started.
	Tension has reduced. It is different now.	GO2…and so I think the tension is coming down. GO1: …It does feel different now.
	Some governance officers no longer feel responsible for the directorates's omissions.	GO1: I don't feel if something has not been done, it's my fault.
	Clinicians' understanding of governance issues is improving.	GO8: Yeah, but that could cause tension sometimes. They are getting to understand the Duty of Candour a bit more now. It is not as bad as it used to it.
	There has been a change in the culture. The culture has moved away from a blame culture. The barriers to being accountable are lifting. It is now easier to make people accountable.	GO10: I think it is the change in culture as well. It is more towards moving towards open and honesty that is becoming more…moving in the right direction, rather than the blame culture where people were willing to sweep things under the carpet if they did not want to be accountable because of the consequences potentially. I am thinking of the barriers are lifting a little bit, so it makes it easier to be …to get accountability.
	Divergence - However, one governance officer felt responsible for omissions of his directorate	GO9: I feel that.

	One governance officer feels the tension.	GO: My line manager… I've just had a phone call from her this afternoon. I can't honestly, sit here and say that I don't feel that. It is not done directly; it is certainly implied that she does hold me personally accountable for what the clinicians and managers do or do not do. There is a general rule.

	Other governance officers can understand why.	GO: I see where GO is coming from cos I used to have the same line manager.
	Personality is important.	GO1: It's personality sometimes.
	They are not able to work efficiently with directorates due to cover.	GO1: You……There are things I would like to be doing, but I am not doing, like checking audit action plans.
	No time to do all that should be done.	GO9: No, I was going to say that cos you haven't got time, though. Yeah.
	Cannot chase NICE guidance effectively due to time factor and eavy workload.	GO1: To…like NICE guidance…if I don't get a response, I would chase and chase, but now, I only chase once.
	Some years ago, governance officers felt responsible. The wards are now taking responsibility for their actions. Years ago, governance officers felt tension when their directorates were underperforming.	GO2: I think sigh! …I'm answering this differently because I don't see myself as accountable. I see it as out there running their ward. They are accountable for their areas. I can advise, I can point to the right direction and do everything that it asked of me, but it is their responsibility to ensure that their staff are working as per policy. Erm, we, as I see it, look at the red flags and try to, you know do some actions to try and help ensure that …..Yeah, it causes tension and you feel. It is a personal feeling when you feel you have let…would you have done something different. To get a better outcome, how would you approach…Whereas, years ago, you feel as if you were responsible that your directorate not achieving what and I think yourself and myself going back a couple of years…and GO1.
	Subtheme 4: Identity of the governance officer	
	Feeling of pride to be a governance officer.	GO2: It makes me feel proud when I can challenge and …

		GO2: Yeah, when I can challenge. You feel confident that you know you were right. You can go in there and then they come out saying, 'Yeah, we are going to have to do it.' (Laugh) Because you've got that conviction, you got that…but that comes with time and I suppose being with your directorates for quite some time …you know.
	Pride is felt when a governance officer can challenge - when they know what they are talking about and they can challenge.	GO8: *Laugh* When you know what you are talking about.

	Respect for governance officer has increased over time.	GO8: I feel I've got a lot more respect from the directorates now than when I did when I first started – but that's been three years in the making. It's taken a long time for them to really…I think they now know that I know what I am talking about. Erm, so that feels good that they respect me a bit more now.
	Governance officers do not have authority	GO1: You don't have that authority.
	They are sometimes disregarded.	GO8: Yeah, I mean, I can chase something for my directorates and get nowhere and then, the manager chases once and she gets a response. So, …
	Band 5s do not have much authority	GO8: Yeah; as a Band 5.
	Governance officers do not have much as they are not at the top level. The relatively low grade/positon within the NHS pay of the governance officer does not give them much authority to ensure accountability with the clinicians	GO8: CDs, the Matrons, the directorate managers, they are very they are the top level. Erm, you only have so much.

	New governance officer feels overwhelmed with the role.	GO10: Overwhelmed! Laugh Yeah. There are a lot of elements on it. I haven't been on the job long enough and I haven't been able to experience what everyone is saying with regards to the obstacles that they experience. Sometimes, how tough it is to get people on board. Erm, so, I don't know. I think it is largely like my past experience about which is like having relations and good rapport. So you have got people on your side as much as you can and to identify when there is conflict within the directorates. And perhaps, how you would speak to one person is different from how you speak to somebody else to get the same results or to get responses from people. So, I think it is really important. Erm, I feel that is what these people are saying as well. That they are all very individual, they are all very different. To get results, you would have to use different approaches. ...different methods to be able to glean what you need. And so, I don't know. I don't know how.

Appendix 16

Clinical Directorate Governance Meeting Agenda

Directorate:

Date of meeting:

Quoracy

3 core members must be present consisting of the following;

- CD/Professional Lead
- Directorate Manager
- Matron
- The Directorate Governance Lead**/**Chair
- Audit Convenor
- *Governance Officer

A representative may be sent in the place of a core member if required.

It is expected that each of the core members will attend a minimum of 8 out of the 12 meetings per year

The Governance Officer will attend **either a pre meet or the main governance meeting.*

Item No.	Agenda Item	CQC Domain	Strategic Objectives
1.	**Apologies** *(Please also ensure the use of job titles)* **Confirm quoracy**		
2.	**Declarations of Interest**		
3.	**Minutes of Last Meeting**		
4. 4.1	**Matters Arising** Action Log		
5 5.1 5.2 5.3 5.4 5.5 5.6	**Incidents** Incident Trends STEIS Reportable Incidents (SUI) And/ Or RCAs Completed SUI Actions Summary monthly incidents (Amber/Red incidents) Unapproved incidents Open over 45 working days	Safe	Culture
6 6.1 6.2 6.3	**Clinical Audit** Annual Audit Plan/ Progress Against Plan Prospective Audit Results/ Reports Open Audit Actions	Effective/ Well Led	Culture/ Performance/ Development
7	**NICE Guidance**	Effective	Culture/ Effective/ Investment
8	**National Guidance**	Effective	Culture/ Development
9	**Risk Register**	Safe/ Well Led	

10 10.1 10.2 10.3	**Claims and Complaints** Complaints trends Personal Injury and clinical negligence Summary monthly complaints	Responsive	Culture/ Effective/ Investment
11 11.1 11.2	**Internal and External Visits/ Reviews** External visits (Including on-going action plans) Quality Review Visits (QRVs)	Effective	Culture/ Development
12 12.1 12.2	**Shared Learning** RCA Synopses Risky Business	Well Led/Safe	Culture/ Effective
13 13.2	**Information Governance** Freedom of information (FOI)	Safe/ Effective/ Well Led	Culture
14	**Never Events**	Safe	Culture
15 15.1	**Health and Safety** Open Safety Alerts	Safe	Culture
16	**Outcome Following Mortality Reviews** *(I.e. Risks/Actions Identified Following The Review)*	Safe	Culture
17	**Policy / Procedure / Patient Information Leaflets**	Safe/ Effective/ Caring/ Well Led	Culture/ Effective
18	**Appraisal / Training Compliance Reports**	Effective/ Well Led	Staff/ Culture/ Effective
19	**Any Other Business** *(May include feedback from relevant Trust groups such as Health & Safety, Patient Safety Improvement Group, Quality Standards Action Group etc.)*		
20	**Matters for Escalation to Division and / or Wider Trust Learning**		
21	**Date and Time of Next Meeting**		
22	**Evaluation of Meeting**		

Strategic Objectives

Strategic Objective	Mapping
Create a culture of compassion, safety and quality	Culture
Be in the top quartile for all performance indicators	Performance
Proactively seek opportunities to develop our services	Development
To have an effective and well integrated organisation that operates efficiently	Effective
Maintain financial health - appropriate investment enhancement to patient services	Investment
Attract, retain and develop our staff and improve employee engagement	Staff