HEALTH SERVICE GOVERNANCE AND CLINICAL SUPERVISION

~A REVIEW ~

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1. Health Service Governance - Clinical Governance

Section 1.1 provides general information on Clinical Governance. Section 1.2 reports on the practical experience of healthcare systems implementing clinical governance and lessons learnt. Section 2 looks at **Clinical Supervision** and its role within **Clinical Governance.**

1.1 Key Features of Clinical Governance and Guidelines for Implementation

Clinical governance: principles into practice mea.elsevierhealth.com, provides a useful overview of clinical governance in a Trust setting. The author suggests that there is no simple recipe for clinical governance and no easy to assemble model of clinical governance, but offers guidelines that may facilitate its introduction.

Structure and chain of responsibility

The Chief executive officer (CEO) of a hospital or primary care trust has ultimate responsibility for assuring quality of care. The CEO has a subcommittee to oversee clinical governance in the trust. Non-executive directors on the sub-committee may act as useful independent advisors to the Board. Recommended membership of the sub-committee includes the CEO, non-executive directors and senior clinicians. The subcommittee is responsible for the strategic development of clinical governance. The presence of the CEO on the subcommittee provides evidence of the importance of clinical governance to the organisation. Clinical governance should be led by a clinician as it concerns clinical practice and a clinical governance lead be established /appointed to be responsible for co-ordinating and monitoring care, providing support to staff and reviewing progress against specified objectives (Clinical governance : principles into practice mea.elsevierhealth.com.) The author suggests the clinical lead can be a doctor often medical director, senior nurse or other senior clinician. The clinical lead should in turn set up a **multidisciplinary team of clinicians** to steer/monitor the day to day development of clinical governance and to provide staff with the necessary support to make this a reality.

Due to the fragmented nature of health care in the community, the establishing of clinical governance is reported to be more challenging. Staff involvement, development and support in this process are seen as key success factors. Within primary care one suggested structure is; a Primary Care Board and Executive to whom a Clinical Governance and Education Team would report. A number of other groups and teams would report to the Clinical Governance and Education Team including specialist working groups, doctors, nurses and practice managers. These teams would in turn get input from a Practice Quality Team. Staff and practices would receive personal development plans and monitoring systems would capture individual and collective performance across established standards and objectives.

The author puts forward the following principles to change healthcare delivery and improve quality of patient care;

- Clinical governance should be mainstream-integral to everyday practice of all healthcare professionals
- Effective Teamwork
  - o clinical governance must be a multidisciplinary activity,
  - o collaboration across disciplines but also interdisciplinary to standardise care for the same patients/disease groups
- Management support
  - o needed from senior management to enable required changes in organisational development as result of clinical governance endeavours/evidence based suggestions
- Leadership by Senior Clinicians
- Collaborative approach/ Collaboration and partnership
  - o Patient involvement
  - o Link primary with secondary care
- Monitor progress against objectives and plans- Monitoring of progress should be routine
- Resources
  - o Staff roles and skill mix to deliver requirements, protected time, IT, training
  - o Available resources should be used to maximum effect.

Carter K., et al. (2011), suggest 3 sets of elements which help support successful integrated care;

- Addressing patient needs in a pathway
- Working in multidisciplinary systems
- Establishing key enablers for support.

Accountability and shared decision making are put forward as elements to support service integration. The authors suggest that accountability begins at the top level with the executive board demonstrating strong support for the integration effort. It notes that primary care physicians are responsible for the delivery of care but that all team members are accountable for patient well-being. The authors recognise the need for appropriate clinical governance mechanisms and standing agreements to support the process. They recommend joint decision making to achieve alignment and "a partnership" approach with all stakeholders having an equal role in decision making.

In addition, clinical leadership is identified as essential for integrated care. Clinical leaders are seen as key figures in the development and updating of evidence based best practice protocols and in facilitating and supporting their implementation in the workplace.

1.2 Examples of Clinical Governance Systems in Practice

1.2.1 NHS Scotland

The Chain of Responsibility in NHS Scotland states;

"Clinical governance is the system through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services, and safeguarding high standards of care and services (NHS Quality Improvement Scotland 2005).

NHS Scotland states that "whilst it is each individual clinician's and employee's responsibility to ensure their practice is safe, it is the Chief Executive who carries ultimate accountability for the quality of care provided within each NHS Health Board (NHS Scotland Healthcare Quality Strategy 2010).

IN NHS Scotland there is a recognition that clinical governance is about the *culture and attitude of staff* working in the health service *as well as specific activities*.

NHS Scotland outlines **3 principles** that need to be in place to achieve effective clinical governance (Governance NHS Scotland, 2013);

- ➢ Clear , robust national and local systems and structures that help identify and report on quality improvement
- ➢ Involving staff, patients and the public
- ➢ Establishing a supportive, inclusive learning culture

Staff Governance

Each NHS Board must operate within the Governance Framework (Clinical Governance, Financial Governance and Staff Governance). Staff governance focuses on how NHS Scotland staff is managed, and feel they are managed. NHS Scotland is striving to be an exemplary employer. Staff Governance is a central aspect of this endeavour.

Employment practices are evolving in NHS Scotland based on the concept of **Partnership working**. Organisations involved in the partnership are:

- Trade Unions
- Professional Organisations
- NHS employers
- The Scottish Government Health Directorates

The NHS Reform (Scotland) Act 2004 saw the commitment to staff governance being reinforced by legislation and supported by the introduction of the Staff Governance Standard which requires certain obligations from employing organisations and the staff working there-in.

NHS Boards must ensure that staff is;

- well informed;

- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

Staff are required to:
- keep themselves up to date with developments relevant to their job within the organisation;
- commit to continuous personal and professional development;
- adhere to the standards set by their regulatory bodies;
- actively participate in discussions on issues that affect them either directly or via their trade union/professional organisation;
- treat all staff and patients with dignity and respect while valuing diversity; and ensure that their actions maintain and promote the health, safety and wellbeing of all staff, patients and carers.

In Scotland the Staff Governance Standard continues to evolve and NHS employers are required to demonstrate that they are striving to both achieve and maintain exemplary employer status. In order to be able to do this, they will be expected to have systems in place to identify areas that require improvement and to develop action plans that will describe how improvements will be made

Staff governance and its underpinning in legislation was a major achievement for NHS Scotland and a first for the United Kingdom. The development and implementation of this Framework demonstrates the proactive approach of trade unions and professional organisations, NHS employers and the Scottish Government to modernising employment practices based on the concept of **partnership working**. This approach has received critical acclaim from independent research by Nottingham University.

An important development within this version of the Framework is the recognition that a responsible organisation that ensures that its employees are fairly and effectively managed within a specified framework of staff governance **can reasonably expect these staff to ensure that they take responsibility for their actions in relation to the organisation, fellow staff, patients, their carers and the general public**. Active engagement of all parties with the principles of good staff governance is essential for NHS Scotland to achieve continuous improvements in service quality which deliver the best possible outcomes for the people of Scotland.

In recent years the NHS Scotland has been developing the concept of a **Partnership Approach to working with Trade Unions (Tus)**. This partnership working has been recognised in NHS Scotland as a critical success factor in achieving the aspiration of a world-class health service designed from a patient's viewpoint conducted so as to facilitate this aspiration. Since 1998, and the establishment of the Scottish Partnership Forum (SPF) all stakeholders were to be involved in formulating policy.

Current National Partnership Structures

There are two key bodies the Scottish Partnership Forum (SPF) and The Scottish Workforce and Staff Governance Committee (SWAG) representing partnership working at a national level. Both bodies are tri-partite, taking their membership from representatives of the Health and Wellbeing Directorate, NHS Scotland Employers and TUs, are co-chaired and have formal constitutions.

The Scottish Partnership Forum exists to provide the Scottish Government, NHS Scotland employers and trade unions/professional organisations an opportunity to work together to improve health services for the people of Scotland. It also provides a forum for all national key policy leads to engage with key stakeholders to inform thinking around national policies on health issues.

Topics discussed at the SPF are shared with the local Area Partnership Forums to ensure that local systems are aware of what is being discussed at National Level.

The SWAG addresses workforce issues that require Scottish-wide solutions, working in conjunction with the SPF to ensure that NHS Scotland operates as an exemplary employer.

Community Health Partnerships (CHP) have been set up across Scotland to provide a wide range of community based health services delivered in homes, health centres and clinics. The CHP have a document which sets out some principles and guidance around governing across partnerships

describing key principles for governance arrangements for joint services (Governance for Joint Services, Principles and Advice 2007).

These include;

- ➢ how partners address the issue of accountability for delivery of joint services,
- ➢ how accountability is preserved across different management structures ,
- ➢ good financial governance for budgets for joint services,
- ➢ issues regarding risk management for joint services

The Scottish Borders CHCP offers an example of the Governance Arrangements in Community Health Partnerships in Scotland (Scottish Borders Community Health and Care Partnership-NHS Borders, 2009).

The Board of the Scottish Borders CHCP is a Strategic Committee accountable to NHS Borders and Scottish Borders Council (SBC). The key functions delegated from NHS Borders Board and the Scottish Borders Council to the CHCP include all governance arrangements relating to services delivered in partnership between the organisation and other stakeholders for adults and older people, mental health, learning disabilities and children's services. This includes joint planning, service redesign, performance monitoring, including Single Outcome Agreement (SOA) and Health Improvement, Efficiency and Access to Services and Treatments (HEAT) targets and commissioning of services. Health Improvement, Drugs and Alcohol Services and Prevention Strategies, Housing and Data Sharing also come under the remit of the CHCP.

The role of the Partnership Board is to:

- to set the strategic vision

- to agree a Strategic Plan for Community Health Partnership working

- to monitor overall progress against joint HEAT targets, Community Health Partnership (CHP) objectives and joint outcomes within the SOA including those for Health Improvement

- ensure structural and cultural barriers to joint working are minimised so that patients and the public experience seamless care and enhanced services

- to hold the Joint Planning and Delivery Committee to account in delivering all the above

Joint Planning & Delivery Committee The committee's role is "*to deliver the CHCP Strategic Plan, monitor governance arrangements, plan, Commission and redesign jointly delivered services, hold Joint Boards and Joint Commissioning Teams to account and drive forward health improvement*". A number of key groups are responsible for achieving this for specific patient / client groups, including the Primary & Community Care Interface Group, the Mental Health & Wellbeing Partnership Board, the Joint Learning Disabilities Board and the Children & Young People's Planning Partnership.

There are joint appointments on boards to encourage alignment of services. The Chairs of the Joint Health Improvement Team (JHIT), the Drug and Alcohol Action Team (DAAT), the Housing Strategy Group and the Data Sharing Partnership are members of the Joint Planning & Delivery Group.

1.2.2 NHS England

(a) Torbay Care Trust (*Torbay and South Devon Health and Care NHS Trust*

In Torbay, Primary Care Teams and Local Authorities had a history of joint working and decided to set up a care trust. Five integrated health and social care teams are aligned with general practices seeking to manage vulnerable service users using single patient-held records. The service model is based on integrated multidisciplinary teams working closely with primary care and specialist health services to deliver care for the target population. Governance is based on a formal agreement between Torbay Council and Torbay Primary Care team. The Local Authority retains accountability for adult social care and an Annual Agreement allows the Council to outline the resources available for social care and performance monitoring agreements. There are capitated budgets for health services. Local teams manage integrated budgets. There is general management across integrated and co-located health and social care teams. A Heath and Social Care Co-ordinator role was introduced to have a single point of contact co-ordinating health and social care for patients. Multidisciplinary teams work across zones. There is a systems based approach to care with hospitals, primary care and

community services encouraged to work in partnership. Senior management at the trust advise the early engagement of senior and middle management to avoid separate arrangements for different professions.

(b) NHS Knowlsey (NHS Knowsley Primary Care Trust)

Knowsley Primary Care Trust serves a population of 161,000 (based on GP practice registration). In **NHS Knowlsey,** efforts are being made to bring together PCT and the council's health responsibilities into a strategic arrangement. A Health and Wellbeing Partnership Board oversees the outcomes, and day to day responsibility is with a partnership management board. The chair is the PCT Chief Executive/Council Executive Director. There is a Partnership Agreement which provides for single accountability with dual governance. In developing the partnership agreement, development days were scheduled and included employment law and a "dignity and respect agenda". There is a Joint Negotiating Consultative Committee (JNCC) which meets monthly and focuses on organisational developments and their implications for staff and the development of the HR/employment strategy. A joint policy and procedure group which develops, reviews and equality impact assesses all human resource policies and procedures and passes these to the JNCC for ratification. Governance staff is represented on the trust board and provider board. The joint policy and procedure group includes 2 experienced union representatives. Trade union representatives contribute to corporate inductions and management development programmes. Widespread involvement of staff representatives and service managers ensures partnership working outside JNCC membership. There is one executive leadership team and commissioning is organised through five executive leads.

1.2.3   (c) NHS North East (NHS Lincolnshire Care Trust)

The **North East Lincolnshire Care Trust Plus** commissions adult health and social care services for a population of circa 170,000 served by 28 GP practices. The trust is described as the first of its type in the country commissioning health and social care together allowing for greater integration between health and social care of services and includes potential for consideration of education, employment, and housing. The trust functions under a Governance Framework and Partnership Agreement. The community care group delivers 7 programmes of care each supported by a unique leadership model; a clinical leader is at the heart of each model and is supported by a community member and service manager. The projects areas are; disability, older people & dementia, planned care, unscheduled care, women & children, prescribing and wellbeing and prevention.

1.2.4   Australia (New South Wales)

Governance in New South Wales Health (Australia) Report of the director general reviewed the functions, responsibilities, structure and relationships of each of the main components of NSW Health (Governance of NSW Health Report of the Director-General 2011). Major considerations were the alignment of each component with Government policy particularly devolution to Local Health Districts, transparency and accountability, and strengthening clinical engagement. The guiding principle was that "every decision and every person" working within NSW Health is focussed on the "best outcome" for patients.

Each Local Health District (LHD) and Speciality Network assumed responsibility for all aspects of hospital and health service delivery for their district under a "Service Agreement" between the Department of Health and the Board of the LHD. Boards established a Performance Agreement with their CEO.

A key element of the Government's health policy is the devolution of the management and governance of the State's public healthcare services to LHD governed by LHD Boards. NSW recently reorganised its public health service from 8 large area health services into 17 Local Health Networks. In the restructuring, the government were conscious to avoid unnecessary administrative layers of bureaucracy. Devolution of functions to LHD was encouraged to occur "unless a clear and compelling reason for delivery on a state wide or other basis" was found. There are 2 Ministers of Health in Australia, one for Health and Medical Research and another Minister for Mental Health and Healthy Lifestyles.

Within the governance framework there is provision for clear allocation of responsibilities, transparency in accountability and linkages and processes between all NSW healthcare providers.

A Governance Review Team was set up to provide expert advice and supports to the Director-General in the conduct of the review. A consultation process with other key stakeholders was held.

The NSW Government Policy is to devolve management and governance of the State's public hospitals and healthcare delivery services to LHD (Speciality Health Networks). It is proposed that each LHD will negotiate a service Agreement with the Department of Health specifying which services will be purchased or funded.

A number of "Pillars" were established to focus on particular aspects of function. The Pillars are in the areas of Clinical Excellence Commission (CEC), Innovation, Health Information and Education/Training. The CEC for example will take responsibility for quality and safety and providing leadership in clinical governance with LHDs.

The Governance approach proposed in NSW seeks to empower local health services, build a sense of joint ownership across the system, improve transparency, accountability and responsiveness within the system.

The review details responsibilities, accountabilities and working relationships of the various entities within NSW Health, emphasising clear delineation and non-duplication of roles and a collaborative approach. It is stated that all entities would have a **joint governance responsibility** for health services.

The review speaks of a number of **critical design factors** which are needed in the governance model to support clinicians and patients to achieve effective care

- Local flexibility and responsiveness requirement of the health services to engage with patients and best meet patient needs and to build linkages across the hospital community sectors.

- Clinician engagement in designing models of care and decision making for local and system wide policies.

- Evidence based policy & effective information systems to support best practice, system management and performance.

- Transparency in funding and decision making.

- Accountability at all levels for performance against validated standards and benchmarks.

- Capable & adaptive work force focused on teamwork and cooperation.

- Effective information and communication technologies to support service delivery and empower patients.

It describes both clearly delineated system wide governance combined with local governance flexibility and accountability in keeping with a "localise where possible, centralise where necessary" philosophy.

1.2.5 New Zealand

A report by the Ministerial Task Group on Clinical Leadership in New Zealand states that decisions around planning and healthcare "demand a balance between clinical, community and corporate governance" (In Good Hands. Transforming Clinical Governance in New Zealand, 2009).

The report states that much effort was being put into corporate governance, the reporting of corporate outcomes, and establishing processes for community governance. However, clinical governance and reporting of clinical outcomes had not been the prime focus of District Health Boards (DHBs) and especially their hospitals.

The report suggests that successful governance within Primary Care Networks requires distributed leadership (at practice, network and national levels) which is happening and that the challenge now is to transform clinical governance into an everyday reality at every level.

The report proposes **6 principles upon which Clinical Governance should be based:**

1. Quality and safety will be the goal of every clinical and administrative initiative.

2. The most effective use of resources occurs when clinical leadership is embedded at every level of the system.
3. Clinical decisions at the closest point of contact will be encouraged.
4. Clinical review of administrative decisions will be enabled.
5. Clinical governance will build on successful initiatives.
6. Clinical governance will embed a transformative new partnership which will be an enabler for better outcomes for patients

The Ministerial Task Group recommends that DHBs establish governance structures which ensure effective partnership of clinical and corporate management and that the Chief Executive enables strong clinical leadership and decision making. In addition, clinical governance must cover the whole patient journey, including horizontal integration across the sector and across primary and secondary/tertiary services.

The Task Group puts forward a series of **tangible examples of clinical governance**, which DHBs must report on including:

a) Clinicians on the Executive Management Team as full active participants in all decision making

b) Effective partnership between clinicians and management at all levels of the organisation with shared decision making, responsibility and accountability.

c) Decisions and trust devolved to the most appropriate clinical units or teams.

d) Clinical leadership must include the whole spectrum from inherent (e.g. bedside, clinical) through peer-elect (e.g. practice, department arrangements) to clinician - management appointment (e.g. clinical directors, clinical board). DHBs must report on the establishment, and effectiveness, of clinical leadership across the spectrum of activities, aligning management to clinical activities.

The report states that empowerment of clinicians is the best means of realising effective clinical governance, and that this must be accompanied by a willingness to accept responsibility and accountability, including for best use of resources.

The Task Group recommends that, at a minimum, DHBs must:

1. Report on clinical outcomes and clinical effectiveness, in a nationally consistent manner.

2. Ensure that quality and safety are at the top of every agenda of every Board meeting and Board report.

3. Assess their own and Chief Executive performance on measures that include clinical outcomes and the establishment of clinical governance.

4. Report on clinical leadership and clinical governance through their District Annual Plans and scorecard reports to the Ministry.

5. Demonstrate clinician involvement at all levels of the organisation including the Executive Management team.**

6. Demonstrate devolvement of decision making and responsibility to the most appropriate clinical unit or team.**

 **The mechanisms for reporting on 5. and 6. must include clinicians themselves.

**An example is existing Joint Consultative Committees.

7. Identify actual and potential clinical leaders, and foster and support the development of clinical leadership at all levels.

8. Coordinate funding, access to internal and external training, and support for coaching and mentoring of leadership at all levels.

The Group recognises the importance of performance measures to drive change and recommends applying the existing well established and validated international leadership metrics to the New Zealand healthcare industry. In addition, they suggest that "a small group be tasked with developing

an initial national framework for reporting on clinical outcomes, clinical effectiveness, and clinical leadership within DHBs. This evidence-based framework should be part of existing reporting mechanisms such as "balanced scorecards" to the Ministry, and should be validated for accuracy by clinician groups within DHBs". The framework would be subject to regular review and updated accordingly as part of a national process to improve the quality and safety of health and disability services. The Task Group recommends sharing successes to encourage others to get involved in the transformation process.

The philosophy is apparent in the following statement by Lord Darzi "*If clinicians are to be held to account for the quality outcomes of the care that they deliver, then they can reasonably expect that they will have the powers to affect those outcomes. This means they must be empowered to set the direction for the services they deliver, to make decisions on resources, and to make decisions on people.*" - Professor of Surgery, the Lord Darzi, Parliamentary Under Secretary of State, Department of health UK. NHS Next Stage Review Final Report, 2008.

1.2.6 Canadian Mental Health

Wiktorowicz et al., (2010), compared models of governance across 10 local mental health networks in diverse contexts (rural/urban and regionalised /non-regionalised). The aim of the project was to clarify the governance processes that foster inter-organisational collaboration and to identify the conditions that support these processes.

In Canada, as elsewhere, there is a shift of mental health care to the community setting. In addition, the Canadian health care system is introducing **Regional Health Authorities (RHA)** charged with the delivery of care to target populations in their location/area. **Networks** act as sub-regional governance structures below RHAs. A number of networks have been established in Canada in the areas of cancer, AIDS, elderly chronic care in a bid to bring about a systems approach to health care. These **Networks** are built around a philosophy of co-operation. Networks require participating organisations to translate their values into a common vision for care and negotiate provision of services and fill service gaps.

For this research, 10 Canadian Mental Health Service Networks, across a mix of diverse contexts, agreed to participate. Mental health networks were set up to provide a means to deliver co-ordinated care to target populations on a regional basis. The goal of the network is to co-ordinate care across primary, secondary, tertiary and social services and to simplify the patient journey.

Governance is coordinated between the RHA and the local networks through their respective executive committees. Governance is described as overseeing the collective action of organisations contracted to provide services and encompasses strategic direction, policy, management and resource utilisation to ensure accountability for performance. Co-ordination of care is assumed under the governance function.

Local mental health networks adopted **one of 3 approaches to govern inter-organisational collaboration;**

  1) corporate structure,

  2) mutual adjustment or

  3) alliance.

In regionalised provinces, RHAs integrated organisations boards through a **corporate structure.** The researchers found the most co-ordinated networks adopted corporate-governed models. In one such network, an initial lack of co-ordination was facilitated by the appointment of director to oversee hospital and community services and committees from both sectors were set-up to facilitate co-ordination.

In small and mid-sized urban networks, governance occurred through an **alliance of organisations** forming an executive team that mediated service coordination. In this approach, organisations retained their autonomy. This form of governance would appear to work best in small and mid –sized urban networks. Due to size, working relationships were developed easier in addition to a stronger sense of accountability.

Large urban networks reported the highest level of coordination through a corporate governance type model, and executive committee. Resources were deployed as needed and these networks reported that union contracts did not prevent shifting of care to the community.

In Ontario's large urban networks the governance model adopted was **mutual adjustment**. This model relied on co-ordination through voluntary exchange without formal co-ordination mechanisms. A Community Investment Fund acts as a financial incentive, encouraging co-ordination of care as programs wishing to expand required a memorandum of understanding with the other organisations in the network to coordinate the service.

If a region had **a psychiatric hospital, its involvement in network governance was described as pivotal** to ensuring coordination. Corporate governed networks in regionalised provinces were held **accountable** for ensuring mental health service coordination. One key feature of successful integration was the central patient intake registry which was proposed to act as a "governance lever" in corporate governance networks.

If networks had budget authority and service planning authority this alignment supported governance capacity prompting organisational coordination/cooperation. Conversely if a province holds budgets for organisations while networks oversee service planning, the key lever is removed and governance was reported to be less well supported. Misalignment was evident where a mental health service was planned by the network while secondary and tertiary facilities were funded by and reported to the province. This divided authority meant hospitals were not held accountable when their care was not co-ordinated with community based organisations (Networks).

Conversely, Network governance was most supported when planning and budget decisions resided at the regional or network level. Provincial control of network budgets was less likely to support governance due to lack of local insight and the lack of a shared vision.

An important governance strategy in Canadian mental health was the formation of sub-networks to address the needs of certain sub-populations e.g. addiction.

The importance of strong leadership in the networks was noted. A team of executives representing the participating organisations assessed needs, decided on resource allocation, etc. Networks reporting successful co-ordination, had governance structures consisting of a network executive committee with representation from all local organisations. Where sub-committees existed, these ensured the executive committee's decisions were carried through into action. An executive forum of governance enabled the advance of shared understanding of goals, roles etc. in a co-ordinated regional manner.

Large metropolitan networks relying on mutual voluntary adjustment were **unlikely to achieve co-ordinated care**. Overly large organisations were seen not to be conductive to community building. In addition, an absence of clear goals and trust amongst organisations hampers integrated care. Incentives may be used to encourage inter-organisational collaboration. The concept of shared governance of network members-a committee of executive directors is proposed. A director across primary and hospital care can be effective where conditions for collaboration are not favourable. A corporate structure with oversight by a regional health authority can lead to inter-organisational collaboration. Sometimes an external brokered form of governance is needed to facilitate the process.

2 Clinical Supervision

There is a difference between the day to day supervision of clinical practice within specific health disciplines and clinical governance. Clinical practice is the monitoring of professional standards of care and practice, which may best be supervised by appropriately skilled superiors in the discipline. Clinical governance has a wider remit. This section looks at the practical experience of clinical supervision in diverse healthcare disciplines and systems.

Clinical Supervision has been defined as "the formal process of professional support and learning that addresses practitioner's development needs in a non-judgemental way. To enable practitioners to deliver an appropriate standard of care and to keep abreast of developments in care, clinical supervision is seen as an integral part of clinical governance. Continuous professional development of staff to maintain high standards of clinical care in a supportive environment is the essence of clinical supervision. The importance of involving clinicians in the supervision process is obvious as is ensuring that those charged with this responsibility have the required knowledge and expertise to carry out the role effectively. Training may be required across the various healthcare disciplines to ensure staff is competent and confident to act as supervisors. Management commitment to the process is seen as a key element in successful clinical supervision along with a bottom up approach and involving a wide range of disciplines (Clifton 2002).

Carpenter and Webb (2012), look principally at the role of supervision from a staff satisfaction and retention perspective, they also consider the practice of supervision in integrated multi-professional teams. They emphasise the essential role of supervision of clinical practice in education and training and suggest that the positive aspects of supervision such as personal development and reflection may be lost if it is viewed purely as part of a system of surveillance. They report on the experiences of supervision in integrated multidisciplinary teams in the UK, Canada and the USA where supervision has been provided by staff from a different discipline. The authors remark on the paucity of evidence regarding the impact of the practice of supervision on service user outcomes.

In the UK clinical supervision usually involves a 1 to 1 meeting with a line manager but could be provided by a senior practitioner or external consultant in the case of reflective practice or professional development. In some cases group supervision takes place. In order for clinical supervision to have the desired principle effect, i.e. to support staff according to the organisations responsibilities and to be accountable to professional standards, Carpenter and Webb (2012), argue that staff need to be "skilful, knowledgeable and clear about their roles and assisted in their practice by sound advice and emotional support from a supervisor with whom they have a good professional relationship".

Reports of a merger of Toronto on Mental health and addiction, (Bogo et al 2011a and b), reported on a merger of 2 addiction services and 2 mental health services where supervision was no longer necessarily provided by someone from staffs' own professional background. Mixed reactions were reported. Some staff reported that their supervisors would not discuss clinical issues but focused on performance management, others were more positive. Safety and trust were rated more important by staff than whether supervision was provide by a member of their own disciple. This project reported that in the area of supervision, job satisfaction and professional development was related to the following components of supervision regardless of whether respondents shared the same professional background; that the supervision was regular, provided by those with expert knowledge and clinical intervention skills for the specific client population, able to teach new and effective treatment methods and that the supervisee was actively involved in the process. Almost all participants agreed, the key elements of an effective supervisor were clinical expertise and an ability to provide new relevant practice knowledge and promote learning in a respectful and safe way and that these factors were more important than professional affiliation. Some employees did comment that meeting with others from within one's own profession was important for profession specific work. A safe confidential space was important in helping staff process the personal aspects of practice experience in contrast to a focus on purely administrative and performance management issues which might be perceived in a negative way by the supervisee

Kavanagh et al., (2003) looked at supervision practices in allied mental health in Australia. and suggests that supervision from one's own professional discipline may be important to performance. The study reported a positive relationship between frequency of contact with supervisors from staffs' own discipline and perceived impact on practice. This was not recorded when supervision was from outside staff' own discipline. They further reported that supervision which prioritised discipline specific skills was strongly associated with impact on practice but time spent on generic skills was not. Kavanagh et al., (2003) suggest that supervision may contribute to better patient care and suggest a targeted approach to skill acquisition and a discipline specific focus may be needed. A positive relationship between supervisor and supervisee emerged as a key feature in terms of job satisfaction and perceived impact on practice.

These findings suggest that supervision by one's own discipline may be important for certain aspects of professional clinical practice. Direct instruction and skills acquisition may only be possible if supervision is provided in a uni-disciplinary fashion.

In a study of home health social workers in the USA, a supervisor's authority in facilitating staff access to resources to meet patient needs was given greater importance compared with professional development and staff mentoring (Egan M. & Kadushin G. 2004). Supervision was viewed as a means of ensuring safe practice and providing learning and development opportunities and enabling staff to represent their discipline in joint and integrated work practice.

The overview of the evidence reported by Carpenter & Webb (2012), suggests that in social work, the overriding priority of supervision is to ensure that work is completed and conforms to acceptable standards. As such, supervision which focused on task assistance may improve performance. The authors believe that supervisors are in a key position to communicate the organisations duties, priorities and goals to the worker and to bring back workers comments to the wider organisation.

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How to set up a managed clinical network – getting started

There are several key stages in the development process for an MCN. Box 1 sets out these stages – from gaining agreement for development to launching the MCN. The development process is likely to take around 12 months; remember that it will be focused on more than one area at a time (Figure 2, overleaf).

BOX 1

Project plan: key development areas

Area of development

1. Secure agreement for MCN development and outline funding from board

2. Identify and appoint project leader and manager
   Secure administrative/secretarial support and a base or office

3. Identify the key clinicians in the area
   Secure the involvement of a project team

4. Draft a development plan and timetable
   Appoint project leader and project manager

5. Hold first meeting of project team to:
   - Agree development plan and timetable
   - Discuss use of allocated budget and identify any potential shortfall
   - Agree number and remit of working groups
   - Discuss possible membership of working groups
   - Identify obstacles to progress and key clinical issues to focus on in development
   - Agree responsibilities

6. Establish working groups and:
   - Agree work programme and working methods for each
   - Agree timetable and key outcomes
   - Undertake development work

7. Arrange regular project team meetings to review, co-ordinate and guide working groups' progress
   Produce regular newsletters

8. Hold open meetings to consult on and refine:
   - Quality assurance programme and standards
   - Care pathways and protocols
   - Any core documents, e.g. referral and discharge documents

9. Finalise and agree quality assurance programme with CSBS

10. Appoint lead clinician(not necessarily the same as project leader) and ratify transfer of project manager and support staff to MCN

11. Launch

MCN = Managed clinical network
CSBS = Clinical Standards Board for Scotland

Managed clinical networks: a guide to implementation

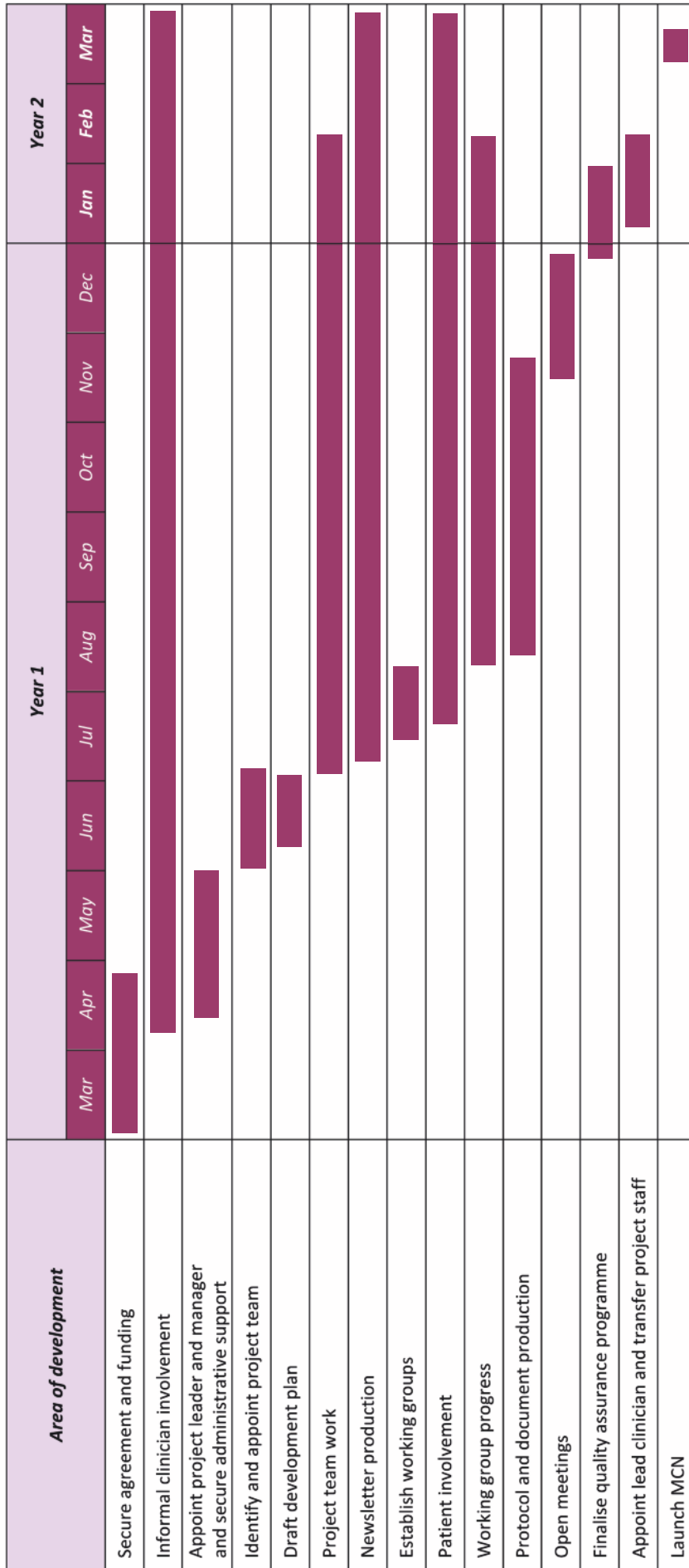| *Area of development*	Year 1										Year 2		
	Mar	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*
Secure agreement and funding		■											
Informal clinician involvement		■											■
Appoint project leader and manager and secure administrative support			■										
Identify and appoint project team				■									
Draft development plan				■									
Project team work				■								■	
Newsletter production					■								■
Establish working groups						■							
Patient involvement					■								■
Working group progress						■						■	
Protocol and document production						■			■				
Open meetings									■	■			
Finalise quality assurance programme										■	■		
Appoint lead clinician and transfer project staff											■	■	
Launch MCN													■

Figure 2. Example of an MCN development timetable