Clinical governance: a customisation of corporate principles. Will it work?

Gareth Jones

Abstract

The introduction of clinical governance in the NHS is designed to increase the quality of care within trusts. Its structure is loosely adapted from commerce, where corporate governance is a well recognised managerial concept. Corporate governance is the concern of senior management, and imbedded in it are the concepts of strategy, direction, and control. Transferring governance structures to the NHS, however, may not be as simple as originally anticipated. Firstly, there is the issue of stakeholdership; whereas corporations give priority to the shareholders’ interests, the NHS has patients, tax payers, and the government, each with different instincts, payoffs, and methods for evaluating success. Secondly, line management: where corporations have definite lines of authority, the health service has complex collegiate interrelationships and peer assessment procedures. Thirdly, in corporations where control over quality follows a hierarchical and pyramidal framework, clinical audit does not. The role of clinical audit will have to be revised such that the setting of clinical standards becomes a joint task for clinicians and management. Finally, in all organisations, management should aim to achieve a degree of specialisation which is aligned with the goals of that organisation. In the context of the NHS this is simply not possible. Until all sides accept major compromises, the chance of success for clinical governance, as a public sector equivalent of the more comprehensive corporate governance, is small.

Keywords: clinical governance; stakeholders; leadership

The introduction of a clinical governance regime into the NHS is designed to increase service quality within trusts through what is essentially a management intervention. It is the chief executives of trusts who will “carry ultimate accountability for the quality of care provided by their trust in the same way that they are already accountable for their trust’s proper use of resources”:1 Clinical governance is a term adapted from commerce, where corporate governance is a well recognised managerial concept.

Corporate governance is concerned with organisational behaviour and organisational culture; it is strategic in nature and involves the direction and control of lower levels of the organisation. The adoption of governance concepts does not mark the first time that the government has attempted to bring commercial ideals into the NHS—one need only think of Rayner in 1979 and Griffiths in 1984. However, the successful transfer of corporate principles into the NHS requires an organisational culture which allows clinical quality to be monitored and maintained from the senior levels of trust management. Governance should be the concern of senior management within any organisation and has been likened to “steering” as opposed to “rowing.”2 However, it is difficult to steer when the rowers also control the tiller.

After 1990, NHS trusts developed a system of governance normally associated with the private sector. Increased financial accountability fell on the individual trusts from the health authorities, and this responsibility was shifted to a large extent on to the shoulders of clinical directors. The present move to augment trust accountability, this time to quality of care, may stem from the fact that, although almost every trust adopted the Johns Hopkins clinical directorate model of the late 1980s, the GMC, BMA, and royal
colleges failed to tackle the question of how consultants influence each other.

The development of clinical governance within the new style of NHS trusts illustrates another attempt to adopt private sector strategies within the public sector: "The intention is to build on existing patterns of professional self regulation and corporate governance principles." How successful this strategy will be is yet to be proved, but in concept it is nothing short of revolutionary.

Several problems will arise from clinical governance. One problem is the lack of a single major stakeholder in the organisation. Governance within a commercial organisation is geared around shareholders. Shareholders, being the owners, are the primary stakeholders of "the firm"; they all have the same ultimate objective (profit) and the same measure of success (increased returns on capital invested). The organisation has a statutory responsibility to uphold shareholder interests in precedence to those of all other parties. In contrast, the NHS has many groups of major stakeholders (for example, patients, tax payers, government), each with different instincts, different methods for evaluating success, and different payoffs. Patients, for example, measure success through personal and subjective experience after contact with the health service. Governments, however, measure success through the maximisation of policy impact and ultimately seek the payoff of re-election. Consequently, instincts and timescales involved are different. If clinical governance is to exist as a method of improving accountability for quality of care it must first be decided to whom trusts should be accountable.

Another issue of concern is line management. In organisations with simple management structures, and even in strict hierarchical corporations, definite lines of authority exist. There are several crucial tenets of line management which need to be embraced for the system to operate efficiently. Firstly, there is the unit of command: any employee should receive orders from only one person. Secondly, there is the scalar chain: the line of authority should run from superior to subordinate. Thirdly, the span of control: the number of people reporting to a superior must not be so large that coordination and communication are broken down. The scale of specialisation and the multidisciplinary nature of the teams in the NHS make much of this virtually impossible.

Arguably, the clinical directorate system was intended to ease the link between managerial control and professional self regulation, but many clinicians view their clinical directors as administrative support rather than as their line manager. A move to clinical governance requires a new look at the role of clinical directors, giving them, for example, powers to limit the practice of subordinate staff if audit reveals unacceptable standards.

Also, the role of clinical audit will have to be revised. The 1989 white paper firmly established audit of patient care as a responsibility for doctors, and there has been no sense of managerial involvement in trust clinical audit committees. If clinical governance is to work within the NHS as corporate governance does in the commercial world, then criteria for audit and clinical standards have to become the agreed property of all levels of the organisation and may become mechanisms for command and control. Is this the intended interface of professional and corporate responsibility? The peer (and self) reviewing clinical audit process, although a useful and positive tool in its current state, has failed to prevent tragedies such as the recent Bristol case of malpractice among paediatric heart surgeons. In the aftermath of this, clinicians may have to face up to management input in the audit cycle—or certainly management monitoring of the process—in an attempt to minimise the opportunity of such an event happening again.

Finally, management in all organisations should aim to achieve a degree of specialisation which is aligned with the goals of that organisation. Once again, in the context of the NHS this is simply not possible. Aside from the fact that the goals at the local level are many and varied, senior managers rarely have the necessary expertise to guide and shape clinical standards. Successful trusts will be those who empower employees at every grade to contribute to the general management process at all levels. In parallel, management will have to recognise that some of the remedial action over low standards lies within the system and not solely with clinicians; what is required is a shared responsibility for monitoring and improving standards.

What is clear is that simply lifting a governance concept from the commercial world and applying it to the NHS with a few changes will not work. Clark et al.
that "treating management as if it is a single entity able to be lifted from one domain (private sector) to another (public sector) ... misses important shifts in internal regimes and modes of power operating within organisations." Compromises are required on all sides to devise a means of internal communication and governance that is both workable and acceptable. Audit will have to become part of the clinical culture, as opposed to being merely something else to do; clinical directors will have to be seen to be empowered as managers, as opposed to simply taking the management title and the associated administrative burden; and the issue of how to discipline "incompetent" or "substandard" clinicians will have to be addressed at all levels of the organisation. Until then, the idea that clinical governance will be successful, as a customisation of the larger and more comprehensive corporate governance, is a weak and short-sighted one.