



A sociological ethnographic study of clinical governance implementation in one NHS Hospital Trust

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271

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Abstract

Purpose – This study aims to give an account of how stakeholders in one NHS Hospital Trust responded to the clinical governance initiative, the effects on quality improvement and the practical accomplishment of legitimacy.

Design/methodology/approach – Sociological new institutionalism theory was utilised to explain the political and ceremonial conformity that marked the clinical governance process. A case study was employed using ethnographic methods. The qualitative data were obtained by documentary analysis, observation of meetings and ward activity and 28 semi-structured interviews. A grounded theory approach was adopted in the analysis of the interviews.

Findings – Errors and inconsistencies were found in Trust documentation and reporting systems were poor. In practice clinical governance was inadequately understood and the corporate goals not shared. Nevertheless, during the same period the Trust obtained recognition for having appropriate structures and systems in place resulting in external legitimacy.

Research limitations/implications – The results only relate to the Trust considered but the study has identified that, although the organization responded to isomorphic governmental pressures in the production of appropriate institutional documentation, the impact of clinical governance to improve the quality in practice was found to be inconsistent.

Practical implications – The Trust promoted and endorsed clinical governance success but the lack of organizational processes and knowledge management equally promoted its failure by denying the resources to implement the desired actions.

Originality/value – Whilst the study identified that clinical governance had been a “ceremonial success”, it is argued that the practical accomplishment in the improvement of quality of care for patients will remain a paper exercise until organizational and practice issues are addressed.

Keywords Clinical governance, Organizational effectiveness, National Health Service, Medical management, Ethnography, United Kingdom

Paper type Research paper

Introduction

According to Davies (2003) organizational studies of the NHS have not been prominent over the past few years. In particular studies of the hospital as a social organization have declined significantly in the last 30 years. This is surprising as the NHS Plan (Department of Health, 2000) constituted the biggest change to health care in England since the inception of the NHS in 1948. This included state intervention, professional regulation, inter-professional and lay relationships, commercial and administrative activities and the use of new health technologies, together with the nursing health care context. It would seem fundamental that essential factors that must be included in any



change is an evidence-base and systematic evaluation. This ethnographic case study provides one such evaluation by presenting an account of how stakeholders in an NHS Hospital Trust responded to the clinical governance initiative, the effects on quality improvement and the practical accomplishment of legitimacy.

Defining clinical governance

Since its appearance as an important element in the Government's focus on improving quality in the NHS, clinical governance has generated considerable discussion on its true meaning, substance and essential nature, in that there are problems in the widely used "official" definition:

A framework through which NHS organizations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish (Department of Health, 1998, p. 33).

This explanation "however" can be criticised because it soon becomes obvious that various connotations can be utilised for "governance," for example; that of supremacy, domination, power or authority and that in this context it is not entirely clear who is doing the governing and who is to be governed. Nevertheless, in this study a "framework" for clinical governance was adopted for identifying the usual components such as standard setting (protocols and policies), risk management, performing audits, adverse incident recording and training, reflection and professional development in the form of a learning organization as described by Easterby-Smith and Lyles (2003).

New institutionalism theory

Sociological new institutionalism theory was utilised as a tool for explanation of the clinical governance process. Institutionalism is a social science approach that examines institutions in order to explain sequences of economic, political and social behaviour. Sociological new institutionalism theory has a specific perspective on institutions in the way that they are socially rewarded by legitimacy, resources and survival, subject to their acceptance of coercive, normative and mimetic institutional pressures. These institutional pressures or change mechanisms are used to achieve "institutional isomorphism," in that the structures, procedures and practices become "similar" across organizational fields (Powell and DiMaggio, 1991).

The attraction of using new institutionalism theory was influenced by Meyer and Rowan's (1977) work on how organizations incorporate structures and procedures that match widely accepted cultural models in order to become "legitimate" they indicate that this "legitimacy" may also be obtained by "ceremonial" actions of the organization. This was felt to be relevant and appropriate when investigating the case study's Trust structures and processes. The use of this theory was also felt to be applicable because of its emphasis on "culture," in that clinical governance literature advocates that clinical governance produces a "cultural change" (Donaldson and Gray, 1998; Scally and Donaldson, 1998; Donaldson, 2000, 2001; Halligan and Donaldson, 2001). However, these articles are mainly theoretical, rhetorical and promotional, and concern separate components within clinical governance, with little or no comment on how the integrated approach might have an advantage in improving care.

New institutionalism approaches have influenced a number of studies of health care organizations. Scott *et al.* (2000) for example examined the transformations that had occurred in the medical care systems in the San Francisco Bay area since 1945 and there has also been increasing interest in applying this approach to studies of the English National Health Service (NHS). Currie and Suhomlinova (2006, p. 1) “highlighted the influence of regulatory normative and cultural-cognitive aspects of institutions operating in the health field on the boundaries that impede knowledge sharing.” Managers, orienting to coercive pressures from the state, did not always recognise the cultural and political dimensions of knowledge sharing, oriented to within the normative frameworks of professionals, so that “knowledge sharing across [professional] boundaries will be difficult to realize.” As Dingwall (2009) states, the result has been a state initiative to undermine professional authority, in the name of quality and safety, in order to weaken the normative influences that check the state’s coercive interventions. This paper is based on my own work (Staniland, 2008), which investigated the implementation of clinical governance, in one English NHS hospital Trust.

The study context

The Trust studied was broadly typical of any large university teaching hospital in England in that wards were structured within directorates with departments actively engaged in teaching and research. The formal designated organizational structure of clinical governance focused on designated committee meetings at various levels, ranging from corporate to directorate level. These consisted of the corporate clinical governance committee, the executive sub-committee, and directorate clinical governance management committees together with their accompanying terms of reference.

Methodology

The study utilized a case study approach using ethnographic methods although some minor quantitative data was produced in respect of numbers and attendance at meetings. The qualitative data were obtained over a two-and-a-half year period by the documentary analysis of papers related to the implementation of clinical governance, observation of clinical governance meetings, day-to-day observation of ward activity and semi-structured interviews with nurses and stakeholders involved in clinical governance implementation within the Trust. In total 67 meetings were observed to include all levels of the organisation, ward observations comprised short stages of four or five hours at any one time over a period of eighteen months in two chosen directorates within the Trust and 13 semi-structured interviews were conducted within a “Nurses” category (comprising of a variety of nursing bands 8 to 5 throughout the organisation) and 15 interviews within the “Stakeholders” category (comprising of groups identified as Consultants, Managers and Professions Allied to Health).

A grounded theory approach was adopted in the analysis of the semi-structured interviews. Grounded theory is an approach to the analysis of qualitative data that aims to generate theory out of research data by achieving a close fit between the two (Strauss and Corbin, 1998; Denzin and Lincoln, 2000). Of specific interest was how nurses translated available “evidence” into their nursing care “practice”, what opportunities there were for this and how they saw their responsibilities in making a

difference to the quality of patient care, using the Essence of Care Benchmarks (the nursing component of clinical governance) (Department of Health, 2003). The Essence of Care initiative related to the commitment made in *Making a Difference*, the National Nursing, Midwifery and Health Visiting Strategy (Department of Health, 1999). The document proposed the area of “benchmarking” as a process through which health care professionals could identify best practice and improve practice through a structured comparison and sharing of information about patient care, within a set framework.

Having transcribed the interview data for each interviewee, in order to begin to ask analytic questions of the data generated, guidelines for the process of grounded theory coding as explained by Charmaz (2006) were followed. Two grids were prepared, one for the nurses and one for the Stakeholders. The answers were re-examined in different ways, for example using grading, grouping, response and directorate. In selecting, sorting and separating data some patterns were found. Using these patterns focused coding was established in order to make decisions about the most analytic sense in which to categorize the data. The themes were regrouped into an analytical framework, under three broad theoretical categories, those of “Making sense” “Knowledge construction” “Real work” and “Somebody else’s job”

Ethical considerations

Appropriate forms were completed for the NHS Local Research Ethics Committee approval. It was also necessary to apply for and obtain an Honorary Research Contract from the Trust for the observation period.

Results

Documents and meetings

The documentary evidence collected initially established that if documents were viewed on a superficial basis, they appeared to be an appropriate account of what had taken place at the meetings. However, when the progress of agenda items from the official minutes were tracked and compared with the researcher’s own observations during the same meetings, it was noted that whilst there were important issues identified for action, these simply did not appear in the documentation again. Whilst it is unrealistic for documents to capture specific detail of the meetings, it was evident that there were many discrepancies between the official documentary records and what was actually done and that that information given to committee members varied in detail. It was established that the approval of hospital protocols and policies, (a main function of the committee), appeared at times to be just a paper exercise (for example at one meeting approval was given to ten protocols in nine minutes). More importantly, the dissemination, implementation and embedding of protocols in working practice was obscure or did not happen.

Other meetings at lower levels of management taking place within the Trust in relation to clinical governance were also observed. The functions of these meetings were to disseminate the clinical governance process during “protected time meetings” (time out given to Trust employees where outpatient clinics were cancelled). In explaining the observation of the meetings, the difficulties of staff trying to make sense of the Trust corporate intentions are described:

Talking about the protected time, now that you mention it, I do remember we were told . . . I remember them [physiotherapists] saying we've got protected time this morning so we're not doing any [work], and I remember thinking well, if they can get it, but we're never going to get protected time because who's going to be left on the ward if that happened? It's the same as everything, we're busy on the ward, the shift's busy it comes to the end of the day you think do I want to go to a meeting or do I want to go home and it's bad, you choose you want to go home I mean . . . (Interview, Ward Sister).

There is comment that the information technology systems set up by the Trust were fraught with problems which were not being addressed at either corporate or directorate level and that protocols and policies, agreed at the corporate clinical governance committee meetings and placed on the hospital intranet, were hard to use as a tool to inform practice, as they were difficult to find and the system slow to use. Nevertheless, complaints made to the corporate level management that these systems were not working, failed to initiate any change.

Using the evidence from field notes and observation, it was established that the Trust corporate organizational, formal goals were ambiguous, not shared, and unrealistic on a day-to-day basis at ward level and that there was little knowledge management, (as defined by Easterby-Smith and Lyles, 2003), evident in respect of clinical governance.

Semi-structured interviews

Emerging themes from interview data were identified under the main categories previously identified. Some relevant comments by the staff are portrayed here; further interview detail is available in Staniland (2008).

Making sense

It was established that consultants could best explain the principles of clinical governance:

. . . Clinical governance is to ensure that what we are doing is good practice, is best practice that we reflect that practice and review what we are doing . . . (Consultant).

Managers generally related it more to "somebody else's job" and other professions had some trouble, as with the nurses, in defining and making sense of it. All professions had problems in explaining how it had affected their role:

From a personal point of view we're not really that involved I don't think and probably should be more involved.

Knowledge construction

In the knowledge construction category, difficulties in communication were apparent, with some managers admitting they did not visit the wards that they were responsible for managing and relied on communicating at meetings that nurses did not attend:

I used to go and visit the wards formally with the previous director and nurses, what I tend to do these days is to drop into the departments, I visit, I do it on a sort of a ad hoc basis and I've done, to be honest I've done it far less in the last 12 months (General Manager).

Real work

In this category, clear professional boundaries and barriers with hierarchical structures were evident in respect of non-sharing of information and one manager acknowledged that a change in culture was still required. It was concluded that at a practice level, overall, clinical governance was poorly understood by both stakeholders and nurses. There was no consistent evidence from these interviews that the integrated approach of clinical governance had an identifiable effect on improvements in the quality of bedside care attributable to the systems set up under the remit of clinical governance:

It's not, it's *ad hoc*, I don't think anyone has really taken full ownership and drawn it into their everyday working practice (General Manager).

There was no agreement from any nurse that clinical governance had raised the quality of bedside care:

[Long pause] "No, I don't"

[Researcher] Could you elaborate on that?

I had to think for a minute to say, to say no . . . as I said earlier that because we now have more documentation and we're more accountable and we have more risk assessments . . . I think sometimes the hands on nursing care is removed . . . we very much now have to rely on, the A Grade and support workers with the hands on care and the feedback from them, because we're actually tied up with the documentation side of things. So I don't think it has improved because sometimes I think you do actually need the trained nurse to do the hands on care, 'cos that's when things are actually identified (Ward Manager).

There was some evidence of increasing awareness of the clinical governance structures and processes and definite confirmation of increased paper work:

In respect of the paper work around clinical governance I would say that possibly half of my time is spent providing either evidence, auditing, or responding to clinical governance issues . . . With the adverse incident reporting again, it's not the actual paperwork it's the system on the computer that doesn't make it particularly easy. But my web master file is absolutely full of it and there is no way of identifying, either on the system, of which, say like. If one of the "gatekeepers" (a gatekeeper refers to the clinical governance facilitator for the directorate) phoned me up and said, I needed some information off one of the adverse incidents she got, it's number 504, there is no way on the system you could find that without going through every single one and there must be thousands, because you've got the original report, my response, the manager's form back then you've got an incident accept, so the file is enormous and there is no way you can link any of them together (Band 7 nurse).

Somebody else's job

It was hard to identify individuals who took corporate responsibility when things went wrong as nobody appeared to take control or responsibility for action, the general impression being that it was somebody else's job:

It's not my job – it's nobody's job, that's the problem (Interview, Senior Manager).

Ward observation

Two accounts of everyday practice from fieldwork notes were presented (Staniland, 2008) because, during the periods of observation, Essence of Care Benchmark best

practice (Department of Health, 2003) were not apparent within one directorate studied and only slightly more visible in the other directorate in that protected meal times (where patients could eat uninterrupted by Trust personnel) were observed and there was some attempt at preserving the privacy and dignity of patients. Activities were carried out as a matter of routine and were not related to the guidance provided in the *Essence of Care*.

Part of one such observation account read:

I [Researcher] observed a cleaner who was busy wiping the cot sides of an occupied bed in one of the side bays. The patient had MRSA and was being nursed in isolation. As I watched, the cleaner went from the cot sides to the bin outside the bay and carefully, using the same cloth, wiped that as well. I asked the sister if the ward had separate cleaners for MRSA infected patients in bays. "No", she responded, "cleaning is a problem, we are always short." I asked how often these bays were cleaned and she did not know. She appeared not to have noticed the activities of the cleaner. I subsequently related this incident to a senior manager and asked what training cleaners had at the Trust. He expressed great concern and said that he was going to check and get back to me, but did not.

Following a medical round, a staff nurse, looking after the patient with the ear trauma asked the sister what she should "pack" his ear with. The consultant had stopped this practice four days previously, the ward sister knew, but the nurse looking after the patient, despite attending ward reports, did not. Following this hectic morning, the sister and I sat for a few minutes at the nurses' station whilst lunch was being served. "How do you know if the care you give is evidence-based?" I asked. She responded that she relied very much on her own experience, as she was not very good with computers. Using the example of the packing of the ear, she said that that was just "common sense" as people are discouraged to clean out their ears with ear buds anyway. I asked her if she used any hospital policies or protocols in her everyday work and she said: "I don't believe the Trust have very many, I rely on the [hospital newsletter] and [name of ward manager] and ward meetings to keep me up to date with what is going on. Like [sic] nobody has ever said to me, this is what you do, in the nicest possible way, we tend to fling the staff into the deep end here as we are so busy."

Discussion

First, it is argued under the new institutionalism framework that whilst the Trust meetings in this study met the "coercive" external criteria (that required a relevant corporate clinical governance committee to be set up in order for the organisation to be recognized as legitimate), in reality, the activities were diverse, the committee appeared ineffective and did not comply with its own terms of reference. It was also noted that the documents produced became increasing "isomorphic" in respect to meeting the guidelines for gaining external legitimacy in relation to what Powell and DiMaggio (1991, pp. 67-72) suggest that organizations in the same field adopt 'similar forms' despite the consequences on the efficiency or effectiveness of that form for their own organization.

In terms of new institutionalism theory, one then has to look at the purpose and need to obtain external organizational legitimacy and the achievements of the Trust over the same period of observation. It is concluded that there was a "coercive ceremonial" management of clinical governance throughout the Trust and the Trust used committees fundamentally to achieve the "external organizational legitimacy", which, in this case, appeared to be more important than quality or effectiveness.

The Trust obtained a three star status and recognition (for having appropriate structures and systems in place) for insurance purposes, of a higher level of compliance with the litigation authority, which carried a significant reduction in insurance premiums. The Trust was also able to produce the appropriate documentation necessary for this “external legitimate recognition” and was viewed as being highly effective by the Strategic Health Authority (in fact statistically the best hospital in the region), which ultimately brought financial incentives to improve services.

In this instance therefore new institutionalism theory was helpful in making sense of what was happening in the Trust and guided the finding that external legitimacy can still be obtained without a clear indication of improvement in quality at grass roots level. Conclusions were that although from a quality improvement and the researcher’s own perspective the clinical governance committee was ineffective, from a new institutionalism viewpoint it was highly effective in that it did accomplish external legitimacy (Meyer and Rowan, 1977) allowing the organization to gain external legitimacy and in bringing financial incentives to the Trust.

It seems logical that clinical staff, responsible for clinical decisions, work in conjunction with managers who, it is suggested should ultimately take the responsibility for putting reliable systems in place. It was evident that, at corporate level, in the context of clinical governance, there was no clearly understood delegation of responsibility and roles were misunderstood, with the result that nobody took any responsibility when things went wrong and issues remained unresolved. It is also suggested that the identified categories of “Knowledge construction” “Making sense” “Real work” and “Somebody else’s job” fit together to produce a workable order for staff. They all put boundaries on workload and commitment that make the job sustainable within available resources.

This paper, by taking a sociological viewpoint of clinical governance implementation in one organization, provides a useful alternative perspective of clinical governance organisational success. If a hospital demonstrates conspicuous, but ceremonial compliance in the production of institutional isomorphic documentation, it becomes legitimate, but it is argued that this affects only the ceremonial order, rather than the culture, delivery of bedside care, patient experience and, indeed, how patients are recognised amongst the members of the organization. In this case, it appears that legitimacy is the pre-condition of organizational success rather than its consequence.

From the data obtained in this study, it is argued that clinical governance has created some potentially unreliable systems within the hospital studied. The whole process concerned with the implementation of procedures in relation to clinical governance clearly affected the nursing personnel, who, at the front line, were trying to use unreliable IT systems in their every day practice. It was clear that the failure of the IT systems and the increase in documentation did result in more time spent away from the patients’ bedside. This raises concern at two levels, the first that managers did not give due regard to reported complaints that the IT systems did not work effectively and this in turn affected the Trust’s “knowledge management” as described by Easterby-Smith and Lyles (2003). The second in that it was believed that change occurred through meetings that nurses, for instance, did not attend.

The need for further independent studies on clinical governance is endorsed, as an important finding in this study is that there is still limited evidence for any improvement in the quality of care at the bedside as a result of the integrated approach

of clinical governance. The intention of this paper is not to make recommendations but to provoke discussion and thought as to whether these findings might be present in other organizations

In summary, by using the theoretical framework of new institutionalism theory to analyse the implementation of clinical governance within a healthcare setting it can be argued that because the hospital is good at producing external paperwork, it disguises that fact that organizational effort is apparently not making care better for patients and may indeed be making it worse, but nobody appears to notice. Sociological new institutionalism theory therefore provides a coherent framework to understand why organizations adopt procedures and practices, which appear to promote uniformity and standardisation. Nevertheless, the evidence reveals some of the complexities, local difficulties and unintended consequences of such processes in a health care setting.

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