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**Clinical Governance:
Striking a Balance Between
Checking and Trusting**

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DISCUSSION PAPER 165

**CLINICAL GOVERNANCE: STRIKING A BALANCE BETWEEN
CHECKING AND TRUSTING**

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ABSTRACT

Clinical governance emerged as one of the big ideas central to the latest round of health reforms. It places with health care managers, for the first time, a statutory duty for quality of care on an equal footing with the pre-existing duty of financial responsibility (Warden 1998). Clinical governance tries to encourage an appropriate emphasis on the quality of clinical services by locating the responsibility for that quality along defined lines of accountability.

This paper explores some of the implications of clinical governance using the economic perspective of principal-agent theory. It examines the ways in which principals seek to overcome the potential for agent opportunism either by reducing asymmetries of information (for example, by using performance data) or by aligning objective functions (for example, by creation of a shared quality culture). As trust and mutuality (or their absence) underpin all principal-agent relationships these issues lie at the heart of the discussion.

The analysis emphasises the need for a balance between techniques that seek to compel performance improvements (through externally applied measurement and management), and approaches that trust to intrinsic professional motivation to deliver high quality services. Of crucial importance in achieving this balance is the creation and maintenance of the right organisational culture.

BACKGROUND

The United Kingdom health care reforms of the early 1990s were characterised by a clarification of budgetary responsibilities within the system, a linking of clinical practice to those financial responsibilities, and an attempt to use market mechanisms to force efficiencies. Almost a decade later, many of the structural changes introduced may have been retained (Baker 1998; Secretary of State for Health 1998b) but the rhetoric has changed: competition is out, co-operation is now in (Goddard and Mannion 1998). Further, both rhetorical emphasis and practical action are now firmly located around issues of health care quality (Thomson 1998).

Box 1: Why the focus on quality of care?

- a burgeoning evidence-base of what works in clinical practice (and what does not);
- the existence of widespread and unacceptable variations - in clinical practice, as well as clinical outcomes;
- a number of manifest and highly public failures of care;
- the emergence of sophisticated data systems and the expertise to mine these for performance-related information;
- a desire to curb costs (as poor quality may be seen in the overuse of treatments and/or iatrogenic harm);
- a political need on the part of the incoming government to find an issue around which to articulate public concern over the NHS which could serve as a focus for health care reform.

The confluence of a great many factors have conspired to bring quality of care issues centre-stage (see Box 1). As a result, these and other trends have loosened a number of previously sacrosanct cornerstones of clinical autonomy and organisational hegemony (see Box 2). Thus there is an unprecedented opportunity for a radical overhaul of how health care is managed in the United Kingdom. Political will and public concern have ensured that the *status quo* is no longer an option. To their credit, many clinicians and their professional organisations do demonstrate a willingness to increase the scrutiny of professional practice. However, recent debates at the General Medical Council over revalidation and medical practice regulation suggest that such willingness is far from universal (Horton 1998b). What is more, experience from the United States has shown that failure on the part of the medical profession to maintain or improve quality while at the same time curbing costs may result in the widespread micromanagement of clinical practice as epitomised by managed care (LeGrand 1998; Robinson and Steiner 1998). Such an outcome would undoubtedly be disturbing and distasteful for many if not most UK clinicians.

Box 2: The loosening of clinical autonomy and organisational hegemony

- the development of general management within the National Health Service;
- the rise of clear financial accountability;
- the emergence of ‘evidence-based medicine’ as a powerful paradigm for clinical practice (together with the organisation of a sizeable reliable evidence-base);
- the explicit use of needs assessment to define desirable service provision;
- a gradual acceptance of the need for cost-effective health care;
- a calling into question of the appropriateness and effectiveness of professional self-regulation (Klein 1998; Smith 1998b);
- the centralisation of standards of acceptable practice, for example, through National Service Frameworks (NHS Executive 1998);
- some tentative questioning of the appropriateness of the existing consultant contractual arrangements in a modern health service (Richards 1998);
- an apparent increase in the willingness to suspend clinicians in the face of allegations of poor performance (Bower 1998).

The nature of clinical governance

Concerns over corporate governance in the private sector welled up in the late 1980s, partly as a result of a number of high-profile corporate failures and scandals. The resulting ‘Cadbury Code’ on corporate governance (Cadbury Committee 1992) attempted to set clear guidance in this area and brought a ‘*new public role to the internal control system*’ (Power 1997). These same principles have been extended to other public services including the NHS (Scally and Donaldson 1998). Clinical governance emerged as a core theme in both the government white paper (Secretary of State for Health 1998b) and the ensuing policy document *A First Class Service* (Secretary of State for Health 1998a). The main components of clinical governance were spelled out as:

- *Clear lines of responsibility and accountability for the overall quality of care.* This includes giving the chief executive the ultimate responsibility for clinical quality, and placing an obligation on NHS Trusts to arrange formal reporting structures that put quality issues on an even footing with financial matters.
- *A comprehensive programme of quality improvement activities.* Measures suggested are: a revitalising of clinical audit, engagement with evidence-based practice; compliance with National Service Frameworks and other national standards; as well as programmes for continuing professional development. High quality data systems and quality assurance programmes are seen as essential for meeting these requirements.
- *Clear policies aimed at managing risks.* Suggestions here emphasise both personal clinical responsibility and the need for effective systematic reduction of risk.
- *Effective procedures to identify and remedy poor performance.* Actionable points listed include the development of critical incident reporting and accessible patient

complaint procedures as a way of identifying learning opportunities. Also highlighted are the need to support staff in their duty to report concerns about colleagues' performance to enable early remedial actions to be taken.

Thus government strategy on clinical performance has centred on a push for more and better information on clinical performance (as set out in the National Performance Framework (NHS Executive 1998)), pitched against clearly defined standards of expected practice to be developed by the National Institute for Clinical Excellence (NICE). A waiting policeman is also on hand to deal with miscreants (the Commission for Health Improvement). The interface between provider organisations and these national enabling initiatives, as well as the internal galvanising of actions aimed at quality improvement, are now gathered under the umbrella term 'clinical governance'.

Doctors have given this part of the white paper a cautious welcome (Black 1998; News report 1998), some noting that clinical governance largely clarifies and structures activities that have always been regarded as the foundations of good professional practice (News report 1998). A recent review of General Practitioners involved in total purchasing did reveal negative attitudes and concerns about clinical governance, but also showed considerable lack of understanding of its nature and implications (Malbon, Gillan and Mays 1998). Dissenting voices have focused on the lack of resources available either to deliver high quality care or to put in place the necessary infrastructure to support quality improvements (Frazer 1998; Richards 1998). As such, cynics suggest that clinical governance is just another tactic to distract clinicians from the bigger issues of increased central control and tight fiscal settlements. Nonetheless, leading articles have congratulated the government for attempting to articulate a clear quality vision together with a detailed and practical strategy aimed at supporting clinical excellence (Donaldson 1998; Scally and Donaldson 1998; Thomson 1998).

Framework for analysis

This paper uses principal-agent theory to examine some of the options for clinical governance. The first section explains the basis of the theory (for non-economists) and outlines its prominent implications. Two of the major approaches to dealing with these implications are then described and evaluated. These are: checking and modifying behaviour using hierarchical control (perhaps allied to incentives); and developing intrinsic professional motivations (through the creation and harnessing of trust). These represent first an attempt to redress asymmetries of information, and second an attempt to align principals' and agents' objectives. What links these and provides a context for all approaches to governance is organisational culture. Thus culture and its implications for organisational performance are also explored. Finally, the paper rounds off with some normative remarks on the need for thoughtful deployment and careful balancing of the various approaches to governance.

PRINCIPAL-AGENT THEORY

Principal-agent theory analyses reciprocal (but nonetheless asymmetric) relationships within and between organisations (Laffont and Tirole 1993). Principals are those actors (individuals or organisations) who want things done. Agents are other actors who are engaged to accomplish these things at the principals' behest. The relationships between principals and agents can take many forms. They may be fixed, tightly controlled and contractual, or they may be loose, informal and shifting. Even when tightly controlled, softer information and informal relationships often underpin formal contracts (Goddard, Mannion and Smith 1998). However a key feature in all these relationships (and the source of possible problems) is the presence of various asymmetries between the two parties.

Agency theory has much to say about the interaction between doctors and patients (Mooney and Ryan 1993). However it has also been used to elicit insights into the organisation and operation of health services in a variety of other ways. For example, agency theory has been used to examine the financial flows in health services (Smith et al. 1997), to explain the emergence, stability and efficiency of different provider structures (Robinson 1997), and to explore the organisational behaviour implications of performance indicators (Davies, Crombie and Mannion 1999). In an analysis of the previous NHS (market-style) reforms, Propper concluded that the National Health Service as reconfigured could be viewed as a series of over-lapping principal-agent relationships with varying incentives (Propper 1995).

In this analysis of clinical governance, *the principals* are service managers (non-clinical or clinical) with primary responsibility for health care quality within the health care organisation (trust or primary care group). *The agents* are those health care professionals through whose effort quality of care may be achieved or lacking. The analysis exposes the difficulties and conflicts that may arise in these relationships and discusses some of the approaches which may be used to overcome these.

Of course, health care professionals (and physicians in particular) are not only the agents of service managers. They are also, most obviously, agents of their patients. This fiduciary relationship is one by which many physicians place great store as they seek to meet their obligations under the Hippocratic oath. Thus clinical governance places physicians and other health care professionals in the position of holding multiple accountabilities which may interact and at times conflict (Shortell et al. 1998).

Problems arising from agency

Difficulties arise in agency relationships because of incongruities and asymmetries between agents and principals. Agents may differ from principals in two main and important ways:

- *Objective functions.* Ambiguity over the objectives of health care may lead to divergent implicit (or even explicit) aims between principals and agents. For example, health care managers may be seeking balanced budgets whereas clinicians may be seeking to maximise health benefits for individuals under their care. Further, principals and agents (even notional ones) are at root people - with various beliefs, attitudes and values, some of which are stable, while others vary by time and context. Thus principals and agents may differ in other important ways, for example, in the values they attach to specific outcomes or their attitudes to risk.
- *Knowledge and information.* Principals and agents have different (though often overlapping) technical knowledge and situation-specific information. They may therefore come to quite different understandings about situations and appropriate actions. For example, even when principals do share objectives, they may differ as to how those objectives are best reached.

These differences between principals and agents open up scope for divergence between what principals want and what agents are able or are prepared to deliver. Agents may for example make undesirable trade-offs between multiple competing objectives, or worse, they may exploit their powerful position to indulge in opportunistic behaviour to maximise their own gain at the expense of the principal. Such opportunism is by definition covert, what Williamson calls '*self-interest seeking with guile*' (Williamson 1993), and is therefore insidious. The accountable officer charged with ensuring health care quality within the organisation thus needs to be cognisant of this potential for (from their perspective) dysfunctional behaviour.

Approaches to agent performance

Various possibilities appear for principals to tackle the potential for sub-optimal agent performance. First they can attempt to exert control through hierarchical organisational structures. For such control to be successful they must be able to measure and monitor those aspects of agent behaviour thought important, and they must have some means at their disposal of exerting influence on agent behaviour in response to observed deviations from desired practice. Such control may be conferred by legitimate power within the organisation or it may be gained by judicious application of incentives (punishments and/or rewards).

A second approach is to seek a negotiated realignment of objectives, knowledge, beliefs etc. - all the factors described above which might give rise to (perceived) agency waywardness. If, as far as possible, agents and principals share a broad and deep understanding about ends, means and the relationships between them, then the agency problems can be minimised without the need for (often costly) control mechanisms. Such a situation arises when principals and agents enjoy a relationship of *mutual trust*: principals trust agents to deliver desired performance; and in return agents trust principals to leave them unmolested in delivering that performance.

A number of linked questions of relevance to clinical governance emerge from this discussion:

- What aspects of agent behaviour and performance should be measured? And what are the strengths and limitations of using such measures to check on agent performance?
- How should performance information be used to prompt agent behaviour change, for example, what control structures are appropriate, and how might incentives be set?
- What is the role played by trust? What are the benefits and risks that might ensue when principals trust agents? And how does checking on agent performance impact on trusting relationships?
- How can principals and agents negotiate a convergence on the factors that contribute to unsatisfactory principal-agent relationships?

It is in seeking insights into these questions that we now address the relative roles of checking and trusting in prompting high performance in clinical practice.

CHECKING AND CONTROLLING

Checking performance and introducing measures to coerce behaviour change are instinctive responses by managers faced with securing performance improvement. In many cases such shocks to the system will indeed produce results. There is ample evidence that tightened control and the application of economic incentives and sanctions can have immediate and marked effects (Flemming and Mayer 1997; Meekings 1995). Such ready successes in various areas of application have legitimised the increased application of performance indicators to health care (Davies and Lampel 1998). The National Performance Framework document (released in support of the white paper) outlined the multifarious ways in which performance measures are expected to be used to drive health care improvements in the 'new' NHS (NHS Executive 1998).

Data *are* an essential tool for reducing one of the important asymmetries between principals and agents (that of information on agent behaviour and subsequent outcomes). Agents themselves also require good quality information if they are to identify deficiencies in practice and respond accordingly. Thus the provision of high quality information on the processes and outcomes of care has much to commend it. However it is also clear that focusing on data to drive improvements has a number of limitations as well as the potential for deleterious effects.

Interpretation difficulties

In using data to assess performance, we want to infer that poor measured performance reflects poor actual performance. Unfortunately many factors intervene to make such causal

attribution weak at best and nonsensical at worst. Variations in apparent performance may arise because of data deficiencies, bias in the measures used, unadjusted case-mix, differential ascertainment of severity data or even just chance variability (Davies and Crombie 1997; Davies and Crombie 1999). Further, data from different sources (for example, administrative data *versus* data derived from clinical records) may tell rather different stories about the quality of care (Hartz and Kuhn 1994). In consequence, poor quality of care may falsely be labelled adequate, or adequate care may unfortunately be judged poor. Thus inferences about quality, especially from routine data sets, may lack both validity and reliability.

Dysfunctional consequences

Smith in particular (Smith 1995a; Smith 1995b) has drawn attention to the various less-than-desirable ways in which organisations and individuals may respond to indicator data. There may, for example, be a tendency to focus on those aspects of care which are measured to the detriment of other important areas; or for emphasis to be placed on narrow or short-term objectives at the expense of long-term global or strategic ends. The fear of falling short on measured performance may also lead to a disinclination to innovate and may elevate a concern to be average over the desire to be outstanding. At the most extreme, powerful incentives may induce gaming behaviour, misrepresentation or even out-and-out fraudulent practice. While empirical research does find some support for these dysfunctional consequences (Goddard, Mannion and Smith 1998; Luce et al. 1996), more usually, unless closely tied to specific actions, indicators are largely ignored (Davies 1998; Goddard, Mannion and Smith 1998; Rainwater, Romano and Antonius 1998).

Backward looking

A more fundamental concern with an over-reliance on performance measurement is that it is inescapably backward looking. That is, using measures to make judgements reflects a concern with picking up past mistakes rather than on pre-emption of those mistakes in the first place. By the time they have been collected, collated, analysed, adjusted and disseminated, performance data may be years out of date. This clearly limits both the relevance and usefulness of these data in securing appropriate behaviour change. Although more recent work has emphasised the benefits of developing on-line measures, available in real-time (Kaplan and Norton 1992), the fact remains that for many measures of health care performance – particularly health outcomes – delays are inevitable.

None of the above observations are to argue that data do not matter. On the contrary, data have an invaluable role to play in any quality improvement programme. Instead, the deficiencies outlined should counsel against demanding more from performance data than they can reasonably support. Many of the problems described arise in part because attempts are made to draw strong inferences from the data. Berwick has highlighted the importance of distinguishing between data to inform quality improvement efforts, as distinct from using data to make judgements (Berwick 1996; Berwick 1998). Thus the crucial consideration is

not the data themselves but the underlying context and culture within which those data are used.

ORGANISATIONAL CULTURE AND QUALITY PERFORMANCE

Recent re-examination of the assumptions underlying the economic perspective on organisational behaviour have led to a number of observations relevant to clinical governance (Granovetter 1992; Mannion and Small 1998). In contrast to the view of organisational actors as being ‘utility-maximising rational individuals’, new economic sociology asserts that other powerful factors come into play, namely:

- that the pursuit of economic goals is also accompanied by the pursuit of non-economic goals such as status, power, reputation and peer-approval;
- that actions are socially situated, embedded as they are in networks of social relations;
- that the institutions within which actions take place are not inevitable but are idiosyncratic and socially constructed.

This socialised view of behaviour enables a link to be made between governance of individuals and the culture of the organisation within which those individuals are situated. Various definitions of organisational culture have been proposed and, although they may differ, they contain a substantial common core: culture consists of that which is shared among organisational colleagues, including shared beliefs, attitudes, values and norms of behaviour. It is a commonly understood way of making sense of the organisation that allows people to see situations and events in similar and distinctive ways (Langfield-Smith 1995; Morgan 1986; Williams, Dobson and Walters 1996).

The notion that organisations possess distinctive cultures, that can be managed to improve performance, has now entered mainstream management thinking. In the 1980s a number of popular management books also proved influential in establishing the notion that culture was the crucial variable separating ‘excellent’ organisations from the also-rans (Peters and Waterman 1982). The NHS has proved no exception to this trend and it is clear that the architects of the latest NHS reforms view the manipulation of culture as an important change-driver to delivering higher quality services:

‘There is need to develop organisations to support a change in culture and deliver change... We want to create a culture in the NHS which supports and encourages success and innovation.’

A First Class Service: Quality in the new NHS, 1998

Here we examine the processes and factors associated with successful cultural change in the context of the proposed NHS reforms. First, it is now recognised that cultural change is no

panacea for poorly performing organisations - and that to be effective such initiatives should be part of a wider set of mutually reinforcing improvement activities (Williams, Dobson and Walters 1996). In this respect, culture should be viewed as merely one of a range of critical variables that an organisation such as the NHS should manage in order to improve performance. Other crucial variables that need to be actively managed include, for example, organisational structure, accounting systems and strategy formulation.

Second, changing an organisational culture is unlikely to be a 'quick-fix' solution. Many corporate case-studies show that transition is often a slow process and can take anything from five to eight years to achieve any real impact (Deal and Kennedy 1992). It seems therefore that the government strategy of evolution rather than revolution, and its commitment to a ten-year programme of modernisation of the NHS, is a realistic assessment of the task ahead.

Third, the experience of many organisations throws into considerable doubt the traditional assumption that cultural change can be imposed top-down by macho-style leadership. It is becoming increasingly clear that changes which do not take into account the concerns and motivations of lower level staff do not generally produce significant and long-standing change (Beer, Eisenstat and Spector 1990). Successful cultural change initiatives appear to embody both clear leadership and attempts to facilitate lower level participation in the decision making process. All this must be fostered by developing a common sense of purpose through education, training and effective communications. (Williams, Dobson and Walters 1996). This holistic approach is in contrast to the rapid improvements frequently sought by the application of measurement and control strategies – for example, recent evidence shows that there are few systematic attempts to communicate the importance and meaning of performance data to front-line staff (Goddard, Mannion and Smith 1998).

A final consideration is the *diversity* of cultures that may be contained within a single organisation - each sub-culture with its own distinctive value-system and affiliations to external social and professional groupings (Langfield-Smith 1995). That multiple cultures can and do coexist within the same NHS trust (albeit with the dominant sub-group being the 'medical clan' (Bourn and Ezzamel 1986)) makes any attempt to instil a unified culture somewhat problematic.

Clearly, changing the culture of the NHS will not be easy. A number of studies in the NHS have shown that, in the face of major re-structuring, continuity is more apparent than change as the dominant culture attempts to neutralise the impact of any reform. For example, attempts to impose a general management culture on to the medical sub-culture in the mid-1980s (through the development of resource management initiatives) met with strong resistance and largely failed to have substantial impact on clinician autonomy (Jones and Dewing 1997). Similarly, there is evidence to suggest that, at least initially, the internal market reforms had little impact on the culture of the medical clan (Broadbent, Laughlin and Shearn 1992). Thus although cultural reform may be a *sine qua non*, all the evidence is that achieving deep and prolonged cultural shifts will be no easy task.

AN EXPLORATION OF TRUST

One key cultural variable receiving increasing recent attention in the social science literature is that of trust. All principal-agent relationships of necessity involve a certain amount of trust as a backdrop to the more explicit hierarchical control, contractual, or incentive-based arrangements. This happens because, in all except the most trivial of relationships, there will be aspects of the desired behaviour of the agent that will be beyond the scope of all reasonable checking. This is especially true of healthcare, which is so multifaceted, uncertain, often immeasurable and frequently hidden from view (consultations which occur in private for example). Thus even in well-specified and detailed contracts, or with comprehensive performance management systems, principals must nonetheless trust that their agents will attend with due diligence to those aspects of care which fall outside of these arrangements.

Even comprehensive control systems involving extensive measurement and audit do not obviate the need for trust. Instead, they demand trust of a different order: trust that the measurement or audit system is itself providing a good account (Power 1997). There is ample evidence that this second-order trust is often misplaced; that audit accounts can give false reassurance or provoke unnecessary alarm (Power 1997). Thus, trust of some sort is inescapable in almost any agency relationship: either direct trust without checking, or indirect trust in the reassurance provided by measures and systems.

The pervasiveness of trust means that it is a key component of many desirable organisational cultures. For example, empowerment as a means of releasing human potential relies on a mutual trust between the empowerers and the empowered. Over 20 years ago Golembiewski & McConkie asserted that *'perhaps there is no single variable which so thoroughly influences interpersonal and group behaviour as does trust'*. In the light of this, the next section examines the nature of trust and its implications for effective clinical governance.

The nature of trust

Trust by one person in another is the subjective assessment that that person will behave in an agreed manner regardless of monitoring, coercion or inducements (Gambetta 1988). Trust then is an *expectation* of competence, predictability and fairness on the part of agents (Zaheer, McEvily and Perrone 1998). Trust arises when a number of conditions hold: when there is a relationship of interdependence and obligation between two parties; when there is uncertainty about the courses of action that may be taken; and when there is a deliberate decision to believe that obligations will be fulfilled.

A relationship where the principal has no choice but to place faith in the agent (i.e. when no alternative approaches are available) is not so much a trusting relationship but more one of dependency. The security of tenure of senior clinicians and the general lack of institutional

leverage over their behaviour leads to some concern that the relationship between health care managers and clinicians may indeed be characterised by some dependency.

This description of trust highlights the inter-personal nature of trust, but trust may also be said to exist between organisations (Lane and Bachmann 1998). For example, the reputation of high-status institutions highlights both the existence of trust lodged in an organisation, and trust that is not dependent on personal experience. Trust may also be placed in specific groups: compare for example the high levels of trust usually commanded by doctors with the proverbial lack of trustworthiness ascribed to second-hand care salesmen. Note also that ascriptions of trust may or may not have a sound basis in reality.

Trust may be difficult and time-consuming to create – for example, it may result from repeated interactions over prolonged periods with slowly evolving confidence. In contrast, trust is easily dissipated through actual or perceived errant or aberrant behaviour. Thus trust may be costly to develop, requiring an investment up-front for uncertain pay-off, and it has the potential for lost investment if adequate trust is never gained or is subsequently lost.

Of necessity, trust also involves exposure to risks: trusted parties may fail to perform to expectations, and may exploit the lack of vigilance afforded by a trusting relationship. Even when opportunism is not a problem, high levels of trust may serve to lock-in parties to certain constrained modes of operation thus reducing flexibility (Lane 1998). Attempting to re-negotiate relationships may then result in a rapid shift from trust to mistrust. It is also worth noting that mistrust is not merely an absence of trust: mistrust brings with it an expectation of opportunistic behaviour (which may or may not be well founded) which demands therefore defensive and costly reassurance arrangements (for example, detailed monitoring, or contracts and litigation).

Notwithstanding the costs and risks of trust, organisations that develop high levels of trust within both internal and external relationships can also expect significant advantages. An obvious benefit arising from trust is a reduction in transaction costs as the overheads associated with contracts and control mechanisms are reduced or eliminated. But this is not the only gain. Trust has been linked to a wide range of desirable organisational outcomes, including improved communication, better teamwork, and increased worker participation (Jones and George 1998; McCauley and Kuhnert 1992; Sashittal, Berman and Ilter 1998). All of these in turn may foster empowerment, innovation and creative problem solving. Employee trust in senior managers has also been found to be a factor in job satisfaction (Driscoll 1978) and commitment to the organisation (McCauley and Kuhnert 1992), and the existence of trust facilitates organisational learning (Koeck 1998).

Trust is starting to be examined as an explanatory variable in models of organisational performance. Even at a societal level, researchers have attempted to use different levels of societal trust to explain varying national economic performance (Fukuyama 1995). Within organisations, there is some evidence that practices which imply a lack of trust may have a deleterious impact on performance by displacing intrinsic motivations (Frey 1997). There are

sound reasons why this might be so in health care (Davies and Lampel 1998). However, these relationships are not simple. For example, some of the literature on performance-related pay suggests that the practice can damage trust and performance (Osterloh and Frey 1998), while others claim that in an existing high-trust environment performance-related pay can be advantageous (National Research Council 1991). Thus the role of trust in improving organisational performance is certain to be highly contingent on the organisational context (including culture). What also remains unclear is whether high performance emerges as a result of high levels of trust within organisations, or whether high-trust is a by-product of high-achieving organisations. That is, even if any relationship can be established between trust and performance it is not immediately clear in which direction any causality may operate.

STRIKING A BALANCE BETWEEN CHECKING AND TRUSTING

Achieving accountability is all about principals calling agents to give an account of their activities and achievements. The main difficulties lie in deciding when an account is called for and what sort of account is appropriate. Following from this is the need to be aware of what it is that accounts (of whatever kind) miss out or de-emphasise, and the need to avoid the production of merely ritualistic accounts (accounts which placate but are neither truly informative nor instrumental (Power 1997)).

Attempting to achieve the aims of clinical governance through measurement and monitoring represents a decision to focus on a certain type of account giving. Such retrospective checking needs to be counterbalanced by developing an appropriate quality-focused and learning-oriented culture. Central to this is the need to develop high levels of trust in those delivering care so that real partnerships can be developed within the organisation. Trusting in healthcare professionals may involve ceding some managerial control but it does not mean abdicating managerial responsibility. That responsibility encompasses articulation of the organisation's mission, values and goals, the provision of leadership, and the development of organisational culture - what Rundall terms the 'bounding of empowerment' (Rundall, Starkweather and Norrish 1998). Thus trust is not the abandonment of controls but is instead the re-emphasising of the power of internal intrinsic motivations over external drivers; control based on shared goals and values, rather than incentives and fault finding.

The appropriate balance between checking and trusting will depend crucially on the nature of the process at issue. When the nature of appropriate agent behaviour is unambiguous and easily measured, then checking may provide useful reassurance and control for principals. In health care, it is more often the case that the outputs from agents are ambiguous and difficult to measure, and the relationships between these outputs and agent behaviour is clouded. In such circumstances, what Ouchi calls 'clan control' (Ouchi 1980) may be more effective. That is, a reliance on shared values and beliefs, and an expectation of reciprocity or trust.

The theoretical benefits of trust receive some support empirically, but more work is required before we can claim to have a robust body of evidence. Nonetheless, the lack of research evidence to support much of the theoretical advantages of trust is more an absence of evidence of any kind rather than evidence that trust is of subsidiary importance. The concern is that insufficient attention will be paid to the sometimes-nebulous concepts of trust and culture in a headlong rush for the more tangible appeals of measurement, monitoring and coercive control mechanisms.

CONCLUDING REMARKS

Clinical Governance provides an important new status for quality of care - giving it legitimate house-room at all managerial levels. As such it may provide a stimulus to co-ordinating and integrating the multiplicity of activities and initiatives currently addressing quality issues. However, with the new responsibility may also come fears: fear of failure, fear of losing control, fear of the unknown. The natural response to such fears is increased measurement hand-in-hand with tighter control. Thus the debate so far has often been dominated by discussion of how best to measure, monitor and correct aberrant behaviour. Recent high-profile instances of manifest failures in clinical practice and dilatory professional responses (for example, the Bristol case (Horton 1998a; Smith 1998a)) have contributed to this atmosphere of regulation and restraint. Talk of 'policing' may be counterbalanced by soothing words on the need to engender the right 'culture' for quality and a renewed emphasis on the importance of leadership (Koeck 1998), but these two components remain uneasy bedfellows.

Measurement, monitoring and control are costly strategies. They are costly not only for the up-front expenses of putting in place information and accountability systems but also for the largely hidden opportunity costs associated with these systems' operation and use. Further, we are not yet clear what intangibles we lose when we abandon trust in professional motivation: *'a system that does not trust people begets people that cannot be trusted'* (Davies and Lampel 1998). Thus, careless use of inappropriate control strategies may introduce new costs and actually impede progress towards quality objectives.

Measurement and explicit control is not the only approach open to those interested in wringing quality improvements from the NHS. As well as reducing information asymmetries, clinical governance also needs to pay sufficient attention to realigning objective functions. Thus the complex nature of health care delivery requires a delicate balance between attempts at control and a fostering of high-trust relationships embedded in a quality culture.

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