Clinical*Governance*

The content in this leaflet is from the publication, *Clinical Governance Manual,* published by Healthcare Quality Quest Ltd.

Healthcare Quality Quest Ltd
Shelley Farm
Shelley Lane
Ower
Romsey
Hampshire
SO51 6AS
Tel: 00 44 (0)23 8081 4024
Fax: 00 44 (0)23 8081 4020
Email: hqq@hqq.co.uk
Web: www.hqq.co.uk

Clinical Governance

Why clinical governance

The following factors led to the need for clinical governance in UK healthcare organizations:

- the relatively **large numbers** of members of the public who lost their lives or were severely **harmed because of significant failures in healthcare organizations** to provide the right clinical care
- the **failure of healthcare organizations** to act in order to stop continuation of the pattern of cases that harmed patients even when the pattern had been made known to those responsible
- the number and cost of claims and **inquiries** and their **findings** (The NHS Community Care Act 1990 provided for the removal of Crown Immunity for the NHS, which enabled the filing of legal claims for unsafe practices in an NHS or other public organization.)
- the **international evidence** on the incidence of harm to patients in healthcare organizations
- the recognition that it is more **morally responsible** (and cheaper) to put systems in place in healthcare organizations to avoid 'clinical disasters' than to have patients or their survivors pursue the causes through the legal system.

What is clinical governance

To be accountable for patient care, a healthcare **organization has to manage:**

- the **quality and safety** of care and service provided by its staff
- **the organization** for the ultimate **purpose of continuously assuring and improving quality and safety** of patient care for the public.

The term clinical governance is used in the NHS in the UK to describe the **corporate duty of quality.** The term is defined in the box.[1–2]

A **system** through which **a healthcare organization is accountable for continuously improving** the **quality** of its services **and safeguarding** high **standards** of care creating an environment in which excellence in clinical care will flourish

The **structures, processes and culture** needed **to ensure** that healthcare **organizations — and** all **individuals** within them — **can assure** the **quality** of the care they provide **and** are **continuously** seeking to **improve** it

Governance is the **framework for accounting** for improving and safeguarding the quality and safety of patient care. It defines the **components of the system to be carried out and how the components are structured, interact and are reported on.**

Activities that make up clinical governance

Several activities are needed to generate information to enable a healthcare organization to be accountable for the quality and safety of care. Staff and the healthcare organization have to:

- **know if the right things are being done in the right way and action is being taken if not** — using ***quality improvement*** tools including ***clinical audit***
- **know and act on what's right** — searching, critically appraising and implementing ***evidence of best practice*** and contributing to research to learn what is best practice
- **know and act on patients' and service users' experiences** — shaping services to provide patient and service user ***centred care*** and acting on ***complaints***
- **know and act on how patients and service users are adversely affected by things** — using ***risk assessment*** and ***management, incident reporting*** and ***root cause analysis,*** and ***patient safety practices*** and ***applying*** the ***lessons*** learned from analysis of incidents

- **know and act on how to do things right** — using appropriate and effective ***appraisal*** systems and ***professional development*** staff programmes
- **be supported to do the right things right** in the work environment — having effective ***leadership*** of teams and making ***changes in systems*** and practices to improve quality.

The purposes of these activities and how they are linked in an operational system are shown in the diagram on the next page. All the activities need **information on quality and safety of patient care to support accountability** by a healthcare organization and its staff. The information should be regularly and routinely available to those who are responsible and accountable for managing clinical services and the healthcare organization.

Accountability framework (clinical governance)


nd acting on
ht — current
wn practice
e-based practice
r and critically
g evidence
Knowing and acting on patients' and service users' experiences
Focusing on patient or service user centred care
Involving patients and service users to improve services
Learning from patient experience and complaints
Acting on information on *Quality and Safety* to support *Accountability*
Information governance
Knowing and acting on how patients or service users are adversely affected by things
Assessing and managing risks
Implementing patient safety practices
Analysing and learning from incidents
acting on
ngs right
hniques
dures
l competence
ofessional
ment

Terms related to clinical governance

There has been some confusion among terms that relate to being responsible for the quality and safety of patient care, including governance, management and practice. Characteristics that differentiate among these concepts are in the box.[3]

Clinical governance	**System, structures and culture** intended **to direct and control** clinical activities **to provide for accountability**
Clinical management	**Processes and procedures by managers to** efficiently, effectively and systematically **deliver high quality and safe clinical care**
Clinical practice	**Delivery by clinicians of high quality and safe clinical care,** consistent with clinical policies and standards

Working together, clinicians and managers implement activities that operate as part of a system to deliver patient care that meets quality and safety expectations.

Clinical governance versus assurance

Clinical governance	A **system** through which a **healthcare organization is accountable** for **continuously improving** the **quality** of its services **and safeguarding** high **standards** of care creating an environment in which excellence in clinical care will flourish Governance is the ***framework*** **for accounting** for improving and safeguarding the quality and safety of patient care.
Assurance	A system for **providing independent confirmation** that **governance is being implemented as intended** and that **findings** from the governance components are being identified and **acted on effectively.** Assurance involves **checking the extent to which an organization is complying** with expectations related to accountability for quality and safety.

Clinical governance components

Quality improvement	**Systematic, data-guided activities** designed to bring about **immediate, positive changes** in the delivery of health care in particular settings.[4]
Clinical audit	A **quality improvement (QI) process** that seeks to improve patient care and outcomes through systematic **review** of care **against explicit measures and** the **implementation of changes** in practice if needed.[5]
Quality assurance	Activities intended to determine **if standards are being met** and to feed back findings so that any deficiencies in meeting standards can be met
Evidence-based practice	The conscientious, explicit and judicious **use of current best evidence,** based on a systematic review of all available evidence and taking into account patient values and circumstances, in making and carrying out decisions about the care of individual patients[6]
Patient experience	How a patient perceives the way healthcare services are provided and whether or not **what matters to the patient is respected** by providers of healthcare services

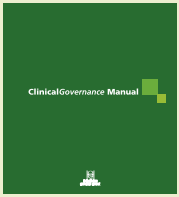
Risk management	Coordinated activities to **direct and control an organization with regard to risk,** involving the **systematic application of** management **policies, procedures and practices** to the: ■ activities of communicating, consulting and establishing the context ■ identifying, analysing, evaluating, treating, monitoring and reviewing risk[7]
Incident reporting	Reporting unintended events during the care process, no matter how seemingly trivial, that resulted, **could have resulted**, or still might result **in harm** to a patient[8]
Root cause analysis	A structured **retrospective analysis** of an event or situation that aims to identify its **true causes** and the **actions** needed to eliminate them, using a wide range of approaches and tools to uncover causes[9]
Patient safety	A discipline in the health care sector that **applies safety science methods** towards the goal of achieving a trustworthy system of healthcare delivery[10]
Appraisal and development	**Formal, regular review** of an employee's role-related **performance** according to standards established for this purpose at the start of the review period

References

1. *Clinical Governance. Quality in the New NHS.* Department of Health, NHS Executive; March 1999 and Scally G, Donaldson LJ. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998;317:61–5.
2. Clinical governance guidance, 19 September 2011. Available at: www.gov.uk/government/news/clinical-governance-guidance. Last accessed 5 April 2019.
3. Brennan NM, Flynn MA. Differentiating clinical governance, clinical management and clinical practice. *Clin Gov* 2013:18(2):114–31.
4. Lynn J, Baily MA, Bottrell M, Jennings B, Levine RJ, Davidoff F, Casarett D, Corrigan J, Fox E, Wynia MK, Agich GJ, O'Kane M, Speroff T, Schyve P, Batalden P, Tunis S, Berlinger N, Cronenwett L, Fitzmaurice JM, Dubler NN, James B. The ethics of using quality improvement methods in health care. *Ann Intern Med* 2007;146:666–73.
5. Adapted from National Institute for Clinical Excellence. *Principles for Best Practice in Clinical Audit*. Abingdon UK: Radcliffe Medical Press; 2002, p.1.
6. Adapted from Sackett DL, Rosenberg WM, Gray JAM, Haynes RB, Richardson WS. Evidence-based medicine: what it is and what it isn't. *BMJ* 1996;312:71–2.
7. *Risk management — Vocabulary. Guide 73. ISO Guide 73:2009.* International Standards Organization; 2009. Available at: https://www.iso.org/standard/44651.html. Last accessed 5 April 2019.
8. Bhasale AL, Miller GC, Reid SE, Britt HC. Analysing potential harm in Australian general practice: an incident-monitoring study. *Med J Aust* 1998:169(2):73–6.
9. *Conducting a Root Cause Analysis in Response to a Sentinel Event.* Oakbrook Terrace IL: Joint Commission on Accreditation of Healthcare Organizations; 1996.
10. Emanuel L, Berwick D, Conway J, Combes J, Hatlie M, Leape L, Reason J, Schyve P, Vincent C, Walton M. What exactly is patient safety? In: Henriksen K, Battles JB, Keyes MA, Grady ML. *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 1: Assessment).* Available at: https://www.ncbi.nlm.nih.gov/books/NBK43629/. Last accessed 5 April 2019.

Our manual

For more information about clinical governance and how to lead or facilitate clinical governance, see our publication.



The ***Clinical Governance Manual*** — 600 pages — describes the background to and concept of clinical governance. Separate chapters describe each of the components of clinical governance — quality improvement, clinical audit, quality assurance, evidence-based practice, patient experience, risk management and assessment, patient safety, incident reporting, root cause analysis, and appraisal and continuing development — and practical evidence-based tools for carrying out the work involved in each component. There are also chapters on the organizational development and leadership issues related to clinical governance.

We offer two versions of our manual. Our ***Clinical Governance Manual*** (aimed at those working in the NHS, private or charity organizations) refers extensively to the Care Quality Commission, whereas our ***Healthcare Governance Manual*** (produced for military personnel) refers to the Common Assurance Framework.

Both the manuals are extensively referenced and contain a detailed glossary. The manuals are easy-to-read with a number of diagrams, charts, examples and exercises.

Our clinical governance course

To develop competence and confidence in carrying out activities, see information about our clinical governance course at www.hqq.co.uk.

Our **Managing Clinical Governance Course** is a four–day course which covers the components of clinical governance in detail and gives practical ideas for how to improve your organization's current performance and to integrate the functioning of the following components:

- quality improvement
- clinical audit
- quality assurance
- implementation of evidence–based practice
- patient experience and involvement, including patient–centred care
- risk management, including risk assessment
- incident reporting, root cause analysis of incidents and patient safety
- performance appraisal and continuing development programmes
- communicating and leading the application of lessons learned.

The course is aimed at clinical and management leaders and staff who specialize in supporting clinical governance.

Participants of the course each receive a copy of our ***Clinical Governance Manual*.**

What people say

Following are examples of what people say about our governance courses.

- "Thank you ever so much for a thoroughly engaging and extremely informative course. You have given me a lot of confidence!"
- "An excellent course overall, thank you very much. The manual will become my bible!"
- "An excellent course that has really helped to clarify and focus all aspects of HCG. My job will now make much more sense and I feel far more confident"
- "A very useful course. Should be mandatory for all leaders in healthcare"
- "This is probably one of the most relevant courses I've ever been on. The facilitator was extremely patient and knowledgeable. Her enthusiasm was infectious and I thank you"
- "The facilitator is a fantastic teacher and extremely knowledgeable"
- "Excellent, patient, and very well pitched facilitation. A refreshing change to have a deep expert deliver complex themes to all levels of healthcare professionals at the same time without being patronizing or overly academic – bravo!"

About Healthcare Quality Quest (HQQ)

We consult, teach and publish on the subject of being accountable for and improving the quality and safety of healthcare services.

We have developed and published methodologies related to clinical audit, quality improvement, and root cause analysis of incidents relating to patient care.

We develop and teach courses and workshops on clinical governance and related methods and activities, including clinical audit, quality improvement, risk management, root cause analysis, patient safety and patient experience and we develop e-learning modules on these subjects as requested.

We also work directly with clinicians and clinical groups, facilitating teamwork where possible. We develop or facilitate the development of standards and examples of good practice in relation to quality of patient care.

We have more than 30 years of experience working in all countries in the UK, as well as Botswana, Holland, Italy, the Republic of Ireland, Saudi Arabia and Taiwan.

For more information about HQQ, please contact us at hqq@hqq.co.uk or 02380 814024.

Shelley Farm, Shelley Lane, Ower, Romsey, Hampshire SO51 6AS
Telephone: 00 44 (0)23 8081 4024 Fax: 00 44 (0)23 8081 4020
Email: hqq@hqq.co.uk Web: www.hqq.co.uk