Clinical Governance - A Toolkit for Clinical Teams

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Introduction

Clinical governance is a framework to ensure continuous quality improvement in health care.

This document is written to support and direct clinical staff in the NHS in Wales in implementing the framework. It gives a short introduction to the elements of clinical governance with a question at the end of each section to direct you in obtaining information prior to additional documents being published. The document also provides some initial guidance on "putting the ideas into practice".

There are three additional documents based on the elements of clinical governance to follow this document. They will be:

**CLINICAL GOVERNANCE- A FOUNDATION TO CLINICAL PRACTICE**
- User and carer involvement
- Risk Management
- Evidence Based Practice
- Information management

**CLINICAL GOVERNANCE-MONITORING PRACTICE FOR IMPROVEMENT**

This document will aid clinicians in deciding how best to monitor their practice. It addresses:
- Audit
- Complaints and compliments
- Benchmarking/Peer Review

**CLINICAL GOVERNANCE - STAFF FOCUS**
- Managing change
- Leadership
- Continual professional development
The supporting documents will all have the same format:

First the big picture – the policy in Wales in relation to the topic covered, including the strategic approach required by the National Assembly for Wales.

Next, how this relates to organisations.

And finally- what does this mean for the individual clinician and the team in which they work. There will be examples of work that has already been developed.

This toolkit and all future release documents are designed to be ‘living’ documents that can be used to support work within clinical teams. The exercises in it can be used as a basis for team discussion and planning.

It is intended that this resource will be of value to all staff throughout the NHS, including contractor professions working mainly in primary care.

There will be information that will be new to some readers and a great deal that will be familiar to others.

The framework of clinical governance does not introduce new individual concepts but brings together existing and well-known quality initiatives, and provides a framework to ensure continuous quality improvement in clinical practice.

For many clinicians providing care in challenging circumstances, clinical governance may feel an additional burden, but it should be an integral part of everything you do and most importantly, it will aid you in ensuring quality in your clinical area.

Although clinical governance is presented as a series of separate component parts, they link together.
ISSUES FOR YOUR CONSIDERATION

Your comments on this document will be welcomed. The information contained in it is not exhaustive.

Please share with us information you have on relevant useful web sites, organisations and contacts that we could include in future documents.

In 2002 a series of supporting documents will be published that give you further information on the component parts of clinical governance.

They will comprise:

**CLINICAL GOVERNANCE- A FOUNDATION TO CLINICAL PRACTICE**

- User and carer involvement
- Risk Management
- Evidence Based Practice
- Information management

**CLINICAL GOVERNANCE-MONITORING PRACTICE FOR IMPROVEMENT**

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**CLINICAL GOVERNANCE - STAFF FOCUS**

- Managing change
- Leadership
- Continual professional development
- People Management
- Culture
If you feel there are issues in relation to implementing clinical governance that are not covered by the above please inform us.

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SECTION 1

THINKING THROUGH THE IDEA OF CLINICAL GOVERNANCE

INTRODUCTION

Clinical governance in the health service in Wales was first announced in 1998 in ‘Putting Patients First’. However, it is not a radically new concept so much as a new way of looking at existing activities in order to improve the quality and safety of clinical care.

Clinical governance is defined in ‘Quality Care and Clinical Excellence’ (Welsh Office, 1999) as:

"a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish".

This means clinical governance is a way of improving and maintaining the quality of the care you provide and being accountable.

Clinical governance is at the centre in the following diagram:
You can see from this diagram that policy in relation to quality improvement falls into three strands:

High Quality Standards

Quality of Delivery

Monitoring and Evaluation of Standards and Delivery

You may well feel you are providing a good quality service and are always trying to improve it. BUT, how can you prove it? How do you show patients, their relatives, or the health service, that you are providing a high quality service?

What documented evidence do you have? How complete and reliable is it?

Looking at your mechanisms for clinical governance and working as a team will help address any identified deficiencies.

GETTING STARTED

Clinical governance is a framework, which brings together component parts.

The components are:

- Patient/ client/ carer experience and involvement
- Clinical Risk management including adverse events, complaints
- Research and effectiveness / evidence based practice
- Information management
- Education, training, continual personal and professional development and professional self regulation
- Clinical audit
- Staff and Staff management
There should be a clear strategy for clinicians, underpinned by leadership, providing direction and integration of the component parts.

There are additional issues clinicians need to have an awareness of such as how to manage change effectively, learning from others and how culture changes.

These parts do not exist in isolation but link and build one on the other to support clinicians in improving the quality of the care they offer and to demonstrate that quality to others.

Clinicians will already be involved in, or have an awareness of, many of the component parts.

Don’t re-invent the wheel, make use of existing systems, structures and knowledge.

**Clinical Governance** is about:

- Every member of the clinical team and the team as a whole.
- Being able to demonstrate the quality of the care you provide, therefore being externally accountable.
- Improving care by providing evidence based care.
- Monitoring the quality of care provided.
- Ensuring your team / clinical area is well managed; that best use is made of resources and staff training needs met.
- Making links across the patient experience / pathway.

**Practical Issues**

Professionals, their teams and organisations must do three things:

1. Be aware of the quality, efficiency and safety of the care they provide.
2. Be accountable, individually and collectively, for it.
3. Continually try to improve it.

One key feature of clinical governance is about creating a supportive culture.
WHAT IS THE CULTURE OF YOUR ORGANISATION AND YOUR TEAM?

Culture involves the way you think and act, and the values you hold.

There are different cultures in organisations. Some are supportive, learning cultures that ensure that lessons are learnt from mistakes. Whilst others have a closed culture that does not make sure that things change when a mistake happens.

Successful clinical governance requires a culture in which team members:

• Are encouraged to discuss their practice and experiences
• Are encouraged to reflect on their practice
• Learn from their mistakes in a safe environment
• Work together to improve services for patients
• Work in partnership with patients and their families
• Value personal development and education
• Feel valued in their work
• Expect to provide evidence based, high quality care
• Expect to record what they do

A team that is attempting to develop a culture where clinical governance can be effective might look like this:
So what is the bottom line on clinical governance?

| Individual: | Examines own performance and shows an interest in the performance of others  
|            | Undertakes professional development with some regard to needs of the team  
|            | Committed to quality improvement |
| Organisation: | Good communication within the team and with partners  
|              | Shared objectives  
|              | Shared decision making  
|              | Effective systems to address potential and actual managerial problems |
| Values: | Committed to quality improvement  
|          | Acceptance of responsibility for patient care  
|          | Acceptance of responsibility for staff welfare  
|          | Commitment to professional development  
|          | Commitment to research and development |

(Adapted from Roland and Baker)

So what is the bottom line on clinical governance?

**WELL, IT WON’T GO AWAY!**
**Duty of Quality**

There are clear lines of responsibility and accountability laid down in the Health Act (1999) which means the Chief Executives of Trusts, Health Authorities and Local Health Groups (LHGs) have ultimate responsibility for assuring the quality of services provided by their organisation.

They do this by:

- ensuring that systems for clinical governance are in place and monitored for their effectiveness
- ensuring formal arrangements exist for Boards to discharge their responsibilities for clinical quality
- ensuring regular reports on the quality of clinical care are given the same importance as monthly financial reports
- ensuring an annual report on clinical governance is submitted to the Board

This does not mean clinical governance is only the Chief Executives concern. It is ultimately their concern but clinical governance is everybody’s business.

**Why has this developed?**

The National Health Service has been concerned about quality for many years. Medical audit evolved into clinical audit and clinical effectiveness led to evidence based practice. These are all initiatives that have addressed the quality of care provided. So looking at quality is not new, but proving it and the emphasis on culture change with all the strands of quality being brought together in a framework is new. Health policy takes a systematic approach to driving up quality standards and improving services for patients.

**References and Further Reading**


Clinical Governance - how Nurses can get Involved. RCN London 2000.


WEB SITES

Health of Wales Information System (HOWIS) http://howis.wales.nhs.uk

National Assembly for Wales http://www.assembly.wales.gov.uk

Health Service Journal http://www.hsj.co.uk
SECTION 2

COMPONENTS OF CLINICAL GOVERNANCE

The following section gives a brief overview of the components of clinical governance and sets some questions for you to consider in your team. The purpose of this section is to stimulate discussion in your team and assist you in where to look for further information.

A scenario from clinical areas is set for you to consider how you will deal with that issue. Some pointers on where to get further information are included.

The following components are addressed:

- Patient/client/carer experience and involvement
- Clinical Risk Management including risk assessment, adverse events, complaints
- Evidence based practice
- Information Management
- Clinical Audit
- Compliments and Complaints
- Bench marking/peer review
- Leadership/people management
- Continuous professional development
USER AND CARER INVOLVEMENT

An essential component of clinical governance is the importance placed on user and carer involvement.

Health policy recognises the value of working in partnership with patients, users and their families and the wider community.

It is easy to talk about user involvement BUT it is challenging to ensure that the partnership is effective and of benefit to all involved.

THINK: As a team, brainstorm the benefits of effectively engaging users to:

- The user and their family
- Your team
- The NHS and its partner organisations

What mechanisms for user involvement have you used?
What mechanisms do you currently use?
Why do you use the mechanisms you do use?
How do you know they are effective?

There are different levels of involvement with users and carers. As well as working in partnership with individual users in planning their care, consultation with users on service planning and organisational change needs to take place.

There are different mechanisms for engaging effectively with users in these different situations.

If you are considering altering services, it might be most effective to form a focus group or use an established patient panel.

Further information will be available in the supporting documents and in Signposts - A Guide to Public and Patient Involvement in Wales that will be published by National Assembly for Wales in the autumn of 2001.
**Scenario**

A clinical team is looking to improve the service it offers to users. Members chatted to a number of patients, who complained about waiting at clinic. The staff think additional clinics are needed.

Is that meaningful involvement?

How could consultation be better?

How can users and carers help us improve the service we offer?

**Where you can find more:** User and Carer Involvement

**References and Further Reading**


Websites

National Assembly for Wales. www.assembly.wales.gov.uk

Community Health Councils
http://www.patienthelp.wales.nhs.uk/CHCList.cfm

Patients Association  http://www.patients-association.com/main.htm

Other

The College of Health, promotes patient involvement through information services, research and audit. In conjunction with Health Development Partnerships, the College has produced a workplace training pack for health care professionals.

The College of Health
St Margaret’s House
Old Ford Road
London E2 9PL
020 8983 1225
CLINICAL RISK MANAGEMENT

We all face risk everyday. We all take risks everyday. We all manage risk taking everyday, often without thinking about it.

When we cross the road, we are assessing how to do it safely. We are probably not aware of the assessment we undertake. We look for a place to cross, consider any potential hazards, make the decision to cross and then do it.

We will always face risk both in our personal and professional lives. We must manage that risk in both areas.

The aim of risk management is to:

• Identify risks
• Reduce or eliminate risks to minimise potential harm
• Deal with the results of the risk taken
• Learn from risk taken and reduce future risk

THINK

• What decisions do you make that might have an effect on the patient and public?
• What risks do you face regularly in your professional life?
• What risks do you face in your team?
• How do you assess those risks?
• Reflect on how you arrived at your decision when making clinical decisions.

Do you think risks are more likely to occur when locum staff are involved?

Are the systems robust enough in your clinical area that unnecessary risks are not taken when staff change?
Planning care with the aid of care pathways not only can improve care for patients but also reduce potential risks being taken by temporary staff, who are unfamiliar with the working environment.

**Scenario**

David Jones arrives for treatment. You have four patients of this name. How do you ensure he is the right patient to receive this treatment?

Do you have a rigorously established process to help you undertake the risk management of this situation?

**Where to find more: Risk Management**

**Further Reading**


**Websites**

Available via HOWIS:
http://nww.wales.nhs.uk/nafw/corpgov/corpgov_e.htm
Evidence Based Practice

Why do you do what you do in your clinical area and practice when you start your working day?

**THINK:** Is your clinical work structured as it is because of

- Custom and practice
- Policy and procedures
- It’s somebody’s good idea
- Evidence of clinical effectiveness
- Reflect on how you arrived at your decision when making clinical decisions.

What is the evidence for the interventions you undertake?

We must increasingly use evidence to underpin decisions we make whether they are policy decisions, service development decisions or clinical decisions.

Evidence can present itself in many ways:

- Research
- Patient experience
- Audit findings
- Epidemiological data
  And the list goes on......

How do you find evidence easily, making sense of it and then apply it?

Try to list the sources of evidence you use.

There are two mechanisms in place centrally that support clinicians in tackling variations in service quality and provision by providing guidance and standards. These are the National Institute for Clinical Excellence (NICE) and National Service Frameworks (NSFs)
NICE is a Special Health Authority established to give advice on best clinical practice to NHS clinicians, to those commissioning NHS services (Health Authorities and Local Health Groups) and to patients and careers. It will assist clinicians in providing the most effective treatments and will help protect patients from ineffective care. NICE will do this by providing authoritative, timely advice on best clinical practice and the effectiveness of interventions. The programme for NICE guidance is aligned to the development of National Service Frameworks (NSFs)

NICE will provide advice by:

- a systematic appraisal of drugs, diagnostic procedures and technologies
- providing guidance on best practice for treating particular clinical conditions, that is clinical guidelines which take into account clinical and cost effectiveness.

This will ensure there are continual improvements in the overall standards of clinical care, a reduction in unacceptable variations in clinical practice and that resources are used to the best benefit of patients.

Appraisals and guidelines are published at regular intervals.

- Check the NICE website. (Paper copies are sent to every NHS organisation. ASK for a copy)

**National Service Frameworks (NSFs)**

National service frameworks have been developed between England and Wales and contain best available evidence of effectiveness with user involvement.

NSFs will set standards to achieve greater consistency in the availability and quality of services for a range of major care areas and disease groups. The clear aim will be to reduce unacceptable variations in care and standards of treatment, using the best evidence of clinical and cost effectiveness.

NSFs will:


• set national standards and define service models for a service or care group
• put in place programmes to support implementation
• establish performance measures against which progress within agreed timescales will be measured

When NSFs are published, a copy is sent to each NHS organisation. Check with your clinical governance lead / department which NSFs have been published.

• What external standards does your team use? (NICE guidance, professional code of conduct, Royal College Standards or guidelines)
  - what external guidelines does the team use consistently?
  - what might you consider using in future after discussion and agreement?
  - are there any practice-wide conventions which, in the absence of external guidelines, might be formalised in your clinical governance system?
  - how do you know about, and systematically consider, new external guidelines?

Help will be provided in the supporting documents. In the meantime, find out if your organisation can access a medical library and is there help available in learning about databases and how to access them.

**Scenario**

You attend a lecture on an aspect of treatment relating to your clinical area.

The lecturer is very dynamic and you think his experience of providing care has produced good results for patients. However, you do not know the published evidence for this treatment.

How do you proceed?
WHERE YOU CAN FIND MORE:  EVIDENCE BASED PRACTICE

FURTHER READING

Getting Evidence into Practice.  Effective Health Care Bulletin No. 5. Royal Society of Medical Press 1999


WEBSITES

National Assembly for Wales. www.assembly.wales.gov.uk

Bandolier http://www.jr2.ox.ac.uk/bandolier

National Institute for Clinical Excellence http://www.nice.org.uk/

NHS Centre for Reviews and Dissemination http://www.york.ac.uk/inst/crd/welcome.htm

Scottish Intercollegiate Guidelines Network http://www.sign.ac.uk/

TRIP Database http://www.tripdatabase.com/

Currently Welsh response to NSFs can be found on the Department of Health website http://www.doh.gov.uk

Implementation plans for Wales:

Tackling CHD in Wales: Implementing Through Evidence http://www.wales.nhs.uk/pubs.cfm
**INFORMATION MANAGEMENT**

When assuring the quality of your services it is crucial to consider how you collect and manage information.

We need to consider how information is gathered, the accuracy and reliability of that information and what use that information is put to.

Technology plays an increasingly large part in our lives. BUT information management is not necessarily about technology; technology is a tool which helps deliver information more effectively.

**THINK**

- How does your team ensure the information they gather is accurate?
- Why are you collecting the information that you are and what does it tell you?
- Does all the team record information in the same way?
- Does each member of the team define the information they are gathering?
- How do you exchange information in your team?
- How do you exchange information with other teams?

Consider a situation where information is exchanged:

- What about handover of patient information between professionals?
- What principles should apply to ensure that information exchange happens effectively?

**SCENARIO**

You receive a referral/transfer letter from a colleague about Mrs Smith’s treatment. It contains only three sentences and does not tell you very much.

What are your transfer letters like?

Do they give adequate information?
Do they contain abbreviations that could be misinterpreted?

The supporting document, as detailed in the introduction, will give you continued guidance.

**WHERE YOU CAN FIND MORE: INFORMATION MANAGEMENT**

**FURTHER READING**

Health Informatics. Competency Profiles for the National Health Service. NHS Information Authority 2000.


**WEBSITES**

National Assembly for Wales    www.assembly.wales.gov.uk

Department of Health    http://www.doh.gov.uk

NHS Information Authority    http://www.nhsia.nhs.uk/def/home.asp
Clinical audit is a systematic reflection on practice. Practitioners examine their practices and results against agreed explicit standards and modify their practice where indicated. Completion of the audit loop enables problems in practice to be identified and changes implemented to improve practice and clinical care for patients.

The standards set must be evidence based. Some of the standards you will be measuring against will be national standards set by the National Institute for Clinical Excellence (NICE) or laid out in the National Service Frameworks (NSFs).

THE KEY STAGES IN THE CLINICAL AUDIT PROCESS ARE:

- Decide on a topic to audit, the reasons for doing the audit, how the quality of care or service is going to be measured in the audit and what is to be included.
- Collect the data on current practice using the agreed measures.
- Evaluate the findings to identify any shortcomings in care and their causes.
- Act to make improvements in care.
- Repeat the data collection, evaluation and action steps as often as needed to achieve and sustain improvements.

(Ref: National Centre for Clinical Audit, 1997)

Clinical Audit is a valuable tool that can help with this, but, audit needs to be simple, regular, and helpful.
As you consider how your team will undertake its clinical governance responsibilities, you may not need to establish new systems but to formalise existing ones.

It is worth thinking through some audit ideas in advance of formalising your clinical governance systems, because there is no point defining processes which cannot easily be checked.

**Scenario**

Sister Anne Williams, on her return from maternity leave having been out of the clinical area for 9 months, is keen to see what changes have been brought about following the major audit the staff undertook in relation to standards of oral care. She finds that no changes have been made despite audit demonstrating that evidence based standards are not being consistently well implemented.

Is this your experience of audit-data collection for data collection sake? A common mistake is thinking that audit results are valuable on their own. Audit results need to be implemented.

All the hard work in agreeing the audit criteria, getting all the staff to participate and collecting the information did not lead to a change in clinical practice and improvements for the patient.

Is the audit stuck somewhere on the audit cycle as illustrated above?

What do you think Sister Williams should do now?

The audit process should be repeated until the evidence of day-to-day practice shows agreed good practice is being implemented routinely.

**Where to find more: Clinical Audit**

**References and Further Reading**


WEBSITES

University of Leicester, Department of General Practice & Primary Health Care http://www.le.ac.uk/cgrdu/

BMA Reference Fact sheets http://library.bma.org.uk/html/audit.html

National Institute for Clinical Excellence http://www.nice.org.uk/

National Prescribing Centre http://www.npc.co.uk/
COMPLAINTS AND COMPLIMENTS

There have always been complaints made and there always will be.

There has been increasing realisation over the years that complaints enable us to learn and change so that services improve and the same complaint does not present time and again. We must learn from our mistakes.

THINK: Consider in your team

• How do you define a complaint?
• How do you record complaints?
• Are all complaints dealt with in the same way?
• Who decides the severity of the complaint?
• Are all of the team defining the severity of complaints in the same way?
• What is your mechanism for sharing complaints received?
• How do you ensure that the team learn from the complaint and that appropriate changes are made?

Think back to the last complaint you received.

How did you learn from that complaint and change something?

Do you know what your organisation expects of you in relation to complaints?

Is training available that will allow you to ensure you have the knowledge and skills you need in dealing with complaints?

COMPLIMENTS

Go back to the THINK box above and go through all the questions in relation to compliments.
Do you keep a record of compliments received? We all need a pat on the back sometimes, if your team has received praise make sure all the team knows. Clinicians can learn from a compliment as well as from complaints.

Consider why a user or their family was satisfied with their episode of care, and what you can learn from it.

**SCENARIO**

The practice manager shows you a letter from a patient complimenting the practice on how they dealt with the care of an elderly relative.

What mechanisms exist to ensure everybody is aware of the compliment and the whole team learns from it?

You could consider addressing complaints in the same way.

**WHERE TO FIND MORE: COMPLAINTS AND COMPLIMENTS**

**REFERENCES AND FURTHER READING**


**WEBSITES**

Kings Fund http://www.kingsfund.org.uk/

Investors in People http://www.iipuk.co.uk/

Community Health Councils http://www.patienthelp.wales.nhs.uk/CHCLList.cfm

Department of Health http://www.doh.gov.uk
BENCHMARKING/ PEER REVIEW

Benchmarking and peer review are mechanisms used to review clinical practice and service provision.

They both mean finding, measuring and implementing better practice.

It can be beneficial and educational to compare what you are doing against what fellow professionals are doing in the same circumstances.

These mechanisms can be useful if there is limited or no evidence available to measure yourself against.

BUT you have to compare like with like:

- Are you offering the same intervention to similar users as your colleague?

Traditionally peer review has been viewed purely as an examination of processes providing an opportunity for groups of health care professionals working in different environments to get together to review aspects of their practise. The aim is to share experiences, support one another and identify areas in which changes can be made with the objective of improving the quality of the service offered to patients. It encourages discussion around the different interventions that professionals offer and aids a professional in learning from colleagues.

In a similar way benchmarking is the continuous process of measuring products, services and practices against leaders, allowing the identification of demonstrably better practice which will lead to measurable improvements in performance. Benchmarking means comparing like with like to strive for being the best of the best.

THINK: The aim is to reduce duplication by learning already found the answer. Find out:

- If anybody in your team has experience of either of these mechanisms.
- Did they find it useful and learn from it?
- Ask your quality/audit/clinical governance department what their views and experiences are of these mechanisms.
SCENARIO

Dr. Davies considered that he kept up to date and was involved in CPD. When he was asked to be a member of a peer review group, he found that other practitioners were having better results with similar patients.

What does Dr Davies need to do next?

WHERE TO FIND MORE:  BENCHMARKING AND PEER REVIEW

FURTHER READING


WEBSITES

British Dental Association  http://www.bda-dentistry.org.uk

Department of Health  http://www.doh.gov.uk

University of Leicester, Department of General Practice & Primary Health Care  http://www.le.ac.uk/cgrdu/
**LEADERSHIP/ PEOPLE MANAGEMENT**

Effective implementation of clinical governance relies on many factors.

These include systems in organisations to monitor practice, effective methods of underpinning practice, and standards to measure against.

BUT without committed staff these things will not be as effective.

The National Assembly for Wales recognises the value of NHS staff in being crucial to deliver high quality effective services for the population of Wales.

Improving Health in Wales  A plan for the NHS with its partners (2001) states :

"The staff of the NHS is one of the greatest assets that we have"

It is crucial to think about staff, their role in clinical governance and what their needs might be to ensure clinical governance is effectively delivered.

What makes an effective leader?

Leadership is defined by Kossen (1983) as:

"Leadership is the ability to influence the behaviour of others to go in a certain direction."

Some might consider this a simple view of leadership but it can be applied to different types of leaders such as military leaders, politicians and team leaders.

The ability to give direction to people is necessary at all levels of an organisation not just at the top of it.

The influence of the board of NHS organisations is crucial in changing attitudes. Their commitment to quality issues sets an example for staff throughout the organisation.
Professionals at all levels of NHS organisations can develop and use leadership qualities as they try to influence the behaviour of others to improve the quality of clinical care.

Clinical leaders must be patient centred and able to build, develop and maintain effective relationships with team members and as well as other professionals.

Leaders must be aware of their own needs as well as those of their team.

**THINK:**

- What qualities do they demonstrate that makes you believe they are effective?
- What qualities do they demonstrate that makes you believe they are effective?
- Have you worked with a professional that held the role/title of leader but you thought did not display leadership qualities? Think about why?

**SCENARIO**

Ms Llewellyn joined a new clinical team. She found established practice was not as evidence based as she would expect. How could she demonstrate leadership to the more junior members of staff to examine practice and improve patient care?

**WHERE TO FIND MORE: LEADERSHIP AND PEOPLE MANAGEMENT**

**REFERENCES AND FURTHER READING**


Ward Leadership Project: a Journey to Patient-centred Leadership. RCN
London 1997


**WEB SITES**


British Dental Association:  http://www.bda-dentistry.org.uk

Department of Health  http://www.doh.gov.uk

Institute of Healthcare Management (some links require membership)
http://www.ihm.org.uk
CONTINUING PERSONAL AND PROFESSIONAL DEVELOPMENT

Continued professional development involves assessing your educational/learning needs and meeting those in a variety of ways that suit your situation and appropriate learning methods.

Do you engage in appraisal?

THINK: As well as your own needs you will have to consider

- Your professional requirements for continued registration.
- Your teams needs. What developments are the team hoping to take forward over the next twelve months?
- Your organisations objectives, what service developments are planned?
- What national strategies will be developed that will relate to your clinical area and how will your team respond to them? Eg NSFs

This is an opportunity to highlight your personal and professional development needs and inform your personal development plan.

How will you be able to meet your needs?
What resources are available to support you?

The supporting documents as detailed in the introduction, may help you answer these questions.

SCENARIO

The organisation that Jane Rees, a physiotherapist, worked in introduced individual performance review (IPR).

Jane knew some of her specific needs, one of which was to increase her ability to use I.T. effectively.

What she was unsure about was the plans of her organisation and how her team were looking to develop.
How is Jane going to ensure her professional needs are met?

WHERE TO FIND MORE: CONTINUING PROFESSIONAL DEVELOPMENT

FURTHER READING


A Review of Continuing Professional Development in General Practice. Calman K, Chief Medical Officer DOH London.

WEBSITES

Centre for Health Leadership Wales site available via HOWIS: http://howis.wales.nhs.uk/directory.cfm?TID=17

British Dental Association http://www.bda-dentistry.org.uk

Department of Health http://www.doh.gov.uk
CULTURE

One of the underlying elements of clinical governance is culture change.

What do we mean by ‘culture’?

Culture involves the way we think and act and the values we hold. A learning, supportive environment that allows professionals and organisations to learn from complaints and compliments, supports staff development and has the patient at the centre of the quality agenda is one where quality improvement will be most easily achieved.

The purpose of the clinical governance framework is to address continuous improvement of the quality of clinical care. Hackett (1999) suggest improving clinical quality by establishing effective clinical governance systems will bring about culture change.

THINK: What is the culture of your organisation and your team?

- Do you feel your organisation expects you to provide a high quality service?
- Can you see evidence in your clinical area/organisation of culture change happening?
- Do you feel supported when you make an error?
- What mechanisms do you use to review your clinical practice?
- Do you keep up to date with best practice in your clinical area?
- Talk to your team about how they feel about the culture of the team and the organisation you work in.

SCENARIO

Mrs Price tells you she does not feel very comfortable with some of the team. She is getting conflicting advice and the team members do not seem to talk to each other.

What does this tell you about the culture of your team? What can you do to improve it?
WHERE TO FIND MORE: CULTURE

REFERENCES AND FURTHER READING


WEBSITES

British Dental Association http://www.bda-dentistry.org.uk
SECTION 3

GETTING STARTED

Following on from section 2, which gives you an overview of the component parts of clinical governance, this section will help you consider evaluating where your team is currently and how you can take forward quality improvements in your clinical area.

WHAT ARE WE ALREADY DOING IN OUR TEAM/CLINICAL AREA?

Although a term that has emerged in the last three years, the component parts of clinical governance are familiar to all of you and you will be at various stages of development at a personal or an organisational level. What is new is that all these areas of responsibility should be recorded and, hence, transparent to those using your services.

PRACTICAL ISSUES

Consider when you ask yourselves the questions below, the strands of clinical governance as already listed in section 2.

• Patient/client/carer experience and involvement
• Clinical Risk Management
• Evidence based practice
• Information Management
• Clinical Audit
• Compliments and Complaints
• Benchmarking/peer review
• Leadership/people management
• Continuous professional development

ASK YOURSELVES

Where are we now?
• Do we hold effective regular team meeting?
• What are we already doing that will help us?
• What can we realistically do in the future?
• How do we start?

Now you need to think about what you do next.

Take some time to address the questions below as a team:

• What quality initiatives is your team involved in currently?
• What other aspects of clinical governance, as listed above, are you involved in?
• Are there activities or data you are recording that could be adapted to help address clinical governance?

**REMEMBER:** it’s not always about working HARDER, but working SMARTER!

So, what are you already doing that will help or can be done differently?

Then, be realistic - what you are likely to be able to achieve?

There will probably be lots of activities and areas you want to tackle, but nothing breeds success like success, so to ensure motivation remains high set a small step for yourselves and be sure to achieve it.

Below are examples of clinical areas that have worked through the questions above.

**ACUTE CLINICAL AREA**

Where are we now?
• No multi-disciplinary team meetings
• High workload, difficult to free up time
• Audit, mainly medically initiated
• Some guidelines used, but no monitoring
• Awareness of clinical pathways but a feeling of ‘where to start’?
What are we already doing?
- Nurse team meetings
- Limited Audit
- Guidelines
- Our documentation is robust
- Excellent library facilities on site
- Supportive audit department

What can we realistically do in the future?
- Meet as a multi-disciplinary team
- Undertake multi-disciplinary audit
- Introduce one clinical pathway

How do we start?
- Identify a team lead for clinical governance
- Hold multi-disciplinary team meeting
- Ask the organisations clinical governance lead to give us some guidance
- Talk to audit department on possible multi-disciplinary audit
- Befriend our librarian
- Get information on clinical pathways
- What NSF/ NICE guidance has been published that is relevant to our clinical area?
- Do we need to have regard for the Health Improvement Plan?

**PRIMARY CARE**

Where are we now?
- Some audits undertaken in the past
- Staff training systems in place
- No experience of monitoring patients views

What are we already doing that will help us?
- We meet as a multi-disciplinary team
- We have audit systems established
- There is an active CHC in our area
- We use I.T. effectively

What can we realistically do in future?
- Extend our range of audits
- Link with local health group audits
- Organise staff training to focus on quality improvements
- Explore if we can use our IT system to support our audits
- Investigate how you can get users views
• Formulate practice development plan

How do we start?
• Choose someone in the team to lead on clinical governance
• Discuss what potential topics we should audit. Consider NSFs and NICE guidance as potential audit topics.
• Talk to CHC about effective user involvement
• Look at potential models to use for practice development plan

LONG TERM CARE

Where are we now?
• Multi-disciplinary care planning meetings
• Staff shortages
• Care plans written for patients on admission but no monitoring
• Standards for care written years ago
• The only audit underway is medical and patchy

What are we already going that will help us?
• Used to working together across agencies
• Documentation is strong
• Have a user and carer group established
• Active ‘Friends of the Unit’
• Recent Trust reconfiguration so potential support available
• We are experienced in care planning

What can we realistically do in the future?
• Revisit standards
• Monitor care plans via audit
• Use Friends group and user and carer group to explore quality issues

How do we start?
• Identify clinical governance lead
• Set aside part of established care planning meetings to address quality
• Learn from your partner agencies how they monitor quality and can you do some joint monitoring
• Talk to your organisations clinical governance lead about the challenges you face and what help is available to overcome them.
PUTTING THE IDEAS INTO PRACTICE

INTRODUCTION

Clinical governance embraces a wide range of activities. There are many activities you can undertake, but clinical governance is about more than ticking off a checklist.

GETTING STARTED

A good place to start is where are we now?

Ask yourselves:

Q Do we understand clinical governance and our role in it?
Q What is our organisation’s plan for clinical governance?
Q Does this organisation have a strategy for clinical governance?
Q What structures have been established?
Q Who are the key people who are involved?
Q Where do we find all of the above information?
Q Who will take responsibility for finding out?

Clinical governance can feel like an overwhelming agenda:

TIP: to eat an elephant break it into bite sized chunks

THINK: As a team think about

* Is this team multi-disciplinary?
* How do we feel about the changes that are going on in the health service?
* How comfortable do we feel, looking honestly at our practice?
* Will we be pleased to share information with patients on our performance?
* Do we have a hierarchical system for decision making in this team? Is the bottom line that the senior clinician decides?
As a clinical team it is useful to think about your expectations of other service providers. What do you look for from the service provided to you by your bank or mechanic?

A quality product or service should be ‘fit for purpose’.

Q What is our clinical teams approach to quality?
Q Have all appropriate staff and team members discussed the quality of care and services they provide?
Q Have staff suggestions been incorporated into policies?
Q Have performance standards been set?
Q Have procedures for delivering the performance standards been made clear to staff?
Q Have staff training needs been assessed and provided to enable staff/team members to meet the performance standards set?
Q What are the monitoring systems in place to review performance?
Q Are systems in place to enable corrective action to be taken when reviews show something is wrong?

After your team has answered the above questions, what does it tell you about quality in your team?

What are your identified strengths and weaknesses?

Can you identify the reasons for your strengths and apply them to your weaknesses?

**TIP:** Don’t try to deal with clinical governance on your own. Involve everyone

Identify your allies
PRACTICAL ISSUES

So, how do we do it?

- Raise awareness of clinical governance. Meet as a team to discuss quality. Perhaps involve an external expert speaker. Approach your organisation’s clinical governance lead/facilitator/team or quality department.
- Remember clinical governance should be a whole team approach.
- Teams vary - in size, skills, and lots of other ways, so think about a clinical governance system that will work for your team.
- Nominate a team lead for clinical governance. Who has the appropriate skills and knowledge?
- Consider rotation of the lead role.
- The nominated lead will need support from team members.
- Let patient needs drive the agenda.

What a Clinical Governance Lead might do:

- Work with the team to devise a plan for clinical governance.
- Help the team get clinical governance activity going.
- Report progress to team meetings.
- Ensure they have the skills needed.
- Identify training needs of team members.
- Ascertain what local support is available.
- Link with the clinical governance lead in their organisation.

The clinician that takes the lead on clinical governance may not be the lead clinician in the team.

Consider the qualities your team think a lead might need, after considering the list above of what a clinical governance lead might do.

TIP: Put yourself in a patient’s shoes and think what would you want in a high quality service?
Building up a portfolio may be one method of pulling together all available information in one place. This will allow members of the team to access information easily.

Consider building a portfolio/file of clinical governance covering:

- Policies  
  (include health and safety)

- Processes  
  (how you do things and the evidence base for that e.g. clinical pathways)

- References  
  (documentation to support processes)

- Checks  
  (Audits or other records that prove you are doing what the policies say you should)

**So, how are you feeling so far?**

Keep it simple and work as a team.

You don’t have to do everything at once - but you do have to make a start.

Remember, only Robinson Crusoe had everything done by Friday!
PROVING THE CLINICAL GOVERNANCE SYSTEM

Your aim is to ensure your clinical governance system is working and that it can be demonstrated to people outside your team.

TIP: There is huge virtue in simplicity

- Start by keeping it simple. Does your team meet regularly? Do you record that you do?

- Do staff undertake appraisal? Have all team members written personal development plans?

- Does everybody in the team understand the audit cycle and the need to complete it?

- Are there already audits in place that can be part of the team's clinical governance system? Can existing audits be changed to meet the needs of clinical governance?

- Does the audit support clinical quality improvement? Do you complete the audit cycle? Do you then reaudit?

- Share the workload. Involve all members of the team. Discuss team members auditing each other’s contribution to care. This aids people’s understanding of each other’s role.

Why doesn’t your team clerk/receptionist audit medical note taking and medical staff audit the process for organising patient appointments?

- Consider ‘random dips’ into certain aspects of the team’s work. Don’t worry too much about statistics, it’s useful to have a ‘snap shot’.

- Consider doing simple regular checks, these can often be more helpful than "one-off" checks.

- Sometimes it is harder to remember to check things that don’t happen very often. Use a wall planner/task completion list. Have a ‘do-by’ book that has listed what checks need to be done by when and who is responsible. When the task is completed, it can be signed off. This reminds everyone of what needs to be done.

- It is possible to audit some events by observation. e.g. how long are patients kept waiting after arrival?
• Sometimes it is of greater value to have more information about a single event. Consider undertaking critical or significant event analysis. How did you investigate the last untoward incident in your team and what did you learn from it?

• Think how the evaluation of success can be transferred to other team activities.

• How can the audit help explain risks to patients? Make ‘risk statements’ to patients that define and measure risk based on your audit findings. e.g. wound infection rate, rate of side effects of treatments. This can help balance rising expectations.

• Keep your audit findings. You may need them in future to demonstrate good practice.

TIP: Audits and checks are proof of good management
LET’S GET PRACTICAL!

Quality management systems build up in layers. Consider building up a portfolio for clinical governance.

Your portfolio might include the following areas:

What you are aiming to do  Policy

How you will deliver the policy  Process

Checks to demonstrate processes are being followed  Monitoring

External guidelines on good practice  References

Clinical governance has regard for the following areas:

- Patient/client/carer experience and involvement
- Clinical Risk Management
- Evidence based practice
- Information Management
- Clinical Audit
- Compliments and Complaints
- Benchmarking/peer review
- Leadership/people management
- Continuous professional development

THINK about:

- the policies you already have in relation to the key areas listed.
- the process you use to implement those policies
- how you know the policy is working effectively
- what is the evidence that you base your policy on.

Now, what policies do you need to develop?
The Portfolio

Consider practical issues such as:

Q How many copies of the portfolio should there be? (It is easier to keep one copy well organised)

Q How will it be updated?

Q Who will be responsible for updating?

Q Consider working out a step by step plan as a team to achieve your aims for clinical governance.

Q Have regular team updates about how the work is progressing.

Q Identify sources of support within your organisation e.g. clinical governance lead, quality or audit department, Local Health Group, professional bodies.

TIP: Establishing a clinical governance system is not a finite job you do once. It is a continuing process that needs to evolve.

Setting your team policy. Think back to when you explored what patients might want from your care. Can you list the likely top ten issues and use these as the basis for your team’s policy? Share them with patients to get feedback.

• How does your list link in with your organisations objectives, the priorities of the local health group action plan and the health improvement plan for the health economy in which you work?

• Consider 'risk management' issues (e.g. record keeping).

• Look at your information management systems and how they might be utilised more effectively.

• Consider appropriate audit as a regular policy.

• Consider including ‘significant event audit’.

• Consider professional development.
The British Dental Association have developed a ‘practice quality system’ that professionals may find useful, particularly independent contractors. It is a straightforward guide for use by the practice team to continuously monitor and improve the quality of their service. Quality Systems for Dental Practice. BDA. April 2000 first edition.

**KEEPING UP TO DATE**

**GETTING STARTED**

Your portfolio/file will need to be kept up to date.

There is a risk that the paper work can get out of hand. Your portfolio needs to be a living document that is meaningful and not just a ‘paper exercise’ that is developed and stuck on a shelf that nobody looks at again.

Brainstorm the following question:

How can this team ensure the information in our portfolio translates into practice to help us improve the quality of care we give?

You may be able to use your portfolio for re-accreditation. Network with other teams in your organisation and in other organisations to learn from each other.

Include in your portfolio:

- A checklist of potential activity
- Useful information from professional organisations
- Publications on clinical governance or any of the separate component parts
- Intra/internet sites that could assist
- Cymruweb/HOWIS (Health of Wales Information Service) may be accessible.
**Clinical Guidance**

Part of clinical governance is using evidence-based guidance (e.g. guidelines, NICE appraisals) where they exist. If none exist consider how you will access evidence and ensure it is incorporated into everyday practice.

It can be a challenge to keep abreast of all the information available in relation to evidence and guidelines.

As a team consider how you are going to keep yourselves up to date and translate that into practice and record it.

- How much of your practice is evidence-based? How do you know?
- What documented "guidelines" (higher level of performance) are being used as opposed to documented "standards" (minimum acceptable performance). Could the amount be increased?
- Keep final drafts of guidelines to no more than one or two sides of A4.
- How will you know the guidelines are being used (think about reviewing practice)?
- What areas of practice produce most queries from team members? Do you need to access or develop guidelines for this area?
- Do you have a clear mechanism for receiving and considering guidance issued from the National Institute of Clinical Excellence (NICE)?
**Practical Issues**

- Access projects, audits and any other work that already exists. Talk to your audit/quality department.

- Get information from professional bodies, Royal Colleges and NICE.

- Use your librarian.

- Consider sources of information other than NHS based. What can you learn from management systems?

- Are areas of your organisation undertaking external quality assurance accreditation? What can you learn from them?
MANAGING CHANGE

This document encourages clinical teams to consider how they will improve the quality of the clinical care they provide. This means changing. You might need to change processes or structures or attitudes. Bringing about change can be very challenging. It requires many skills - perception, analysis, self-awareness, planning, communication, education and evaluation.

You have to be clear what needs changing. Is it clinical practice (what is done) or clinical process (how it is done)? It might be a bit of both.

The basic principles of change are:

- Be clear what kind of change is required.
- Plan carefully. Identify everyone who is affected by the change.
- Communicate.
- Win over doubters with early success.
- Having measures available that will tell you the change has been successful.

SCENARIO

Mrs Patel arrives for treatment in your clinical area.

How would you obtain consent from her? What information would you give her to arrive at this decision today and how is the process and information different from what you would have done three years ago?

While you may not have consciously set out to modify practice you have undergone a process to bring about this change.

Reflect on this issue and how you managed the demands of this change.

What knowledge, awareness, training and process have you had to develop to bring about the change?
Does your team communicate effectively with each other? How do you know? Could it be better?

The supporting document, as defined in the introduction, will aid you in managing the change you need to bring about.

**FURTHER READING**


**GENERAL WEBSITES**

NHS Centre for Reviews and Dissemination

http://www.york.ac.uk/inst/crd
The NLM Gateway allows users to search in multiple retrieval systems at the U.S. National Library of Medicine (NLM). The current Gateway searches MEDLINE/PubMed, OLDMEDLINE, LOCATORplus, Health Services Research Meetings, HSRProj, MEDLINEplus and DIRLINE.

http://gateway.nlm.nih.gov/gw/Cmd

The Cochrane Effective Practice and Organisation Group (EPOC)

http://www.abdn.ac.uk/public_health/hsru/epoc/

WISDOM Centre (this site has an extensive bibliography listing various journal articles on clinical governance)

http://www.shef.ac.uk/uni/projects/wrp/cgbiblio
Bibliography:


Clinical Governance a Practical Guide for Primary Care Teams. Roland M, Baker R. National Primary Care Research and Development Centre, University of Manchester. Clinical Governance Research & Development Unit, University of Leicester.


Health Informatics Competency Profiles for the National Health Service NHS Information Authority 2000


Learning to Manage Information. NHS Executive 1999


Quality Systems for Dental Practice. BDA. April 2000 first edition


Self Assessment Manual and Standards - Clinical Standards in General Dental Practice. Advisory Board in General Dental Practice. 1991

The Essence of Audit. The National Working Group on Clinical Audit in Community Dental Practice. 1992

The Clinical Audit Handbook Improving the Quality of Healthcare. Morrell C, Harvey G. RCN (Bailliere Tindall) 1999

The Good CPD Guide. Grant J, Chambers E, Jackson G. Reed Healthcare Sutton 1999


The Quality Gurus - Managing in the 90s. DTI URN 95/657.


WEBSITES:

Bandolier
http://www.jr2.ox.ac.uk/bandolier/

Best Evidence 4 database
http://www.bmjrg.com/template.cfm?name=specjou_be#best_evidence

Cochrane Library. via the National electronic Library for Health:
http://www.nhs.uk/nelh/ or

Commission for Health Improvement
http://www.chi.nhs.uk/

Database of Abstracts of Reviews of Effectiveness (DARE)
http://www.york.ac.uk/inst/crd/

Effective Health Care Bulletins
http://www.york.ac.uk/inst/crd/ehcb.htm.

Health of Wales Information System (HOWIS)
http://howis.wales.nhs.uk

National Assembly for Wales
http://www.assembly.wales.gov.uk

National Electronic Library for Health (NeLH)
http://www.nhs.uk/nelh/

National Institute for Clinical Excellence
http://www.nice.org.uk

Netting the Evidence
http://www.shef.ac.uk/~scharr/ir/netting

NHS Centre for Reviews and Dissemination
http://www.york.ac.uk/inst/crd

TRIP database
http://www.tripdatabase.com/

WISDOM Centre (this site has an extensive bibliography listing various journal articles on clinical governance)
http://www.shef.ac.uk/uni/projects/wrp/cgbiblio