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Clinical governance in action

Learning from experience: a case study of clinical governance in action

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ABSTRACT

Objective To share the experiences of a primary care organisation in its approach to learning from experience.

Design A case study approach was used to consider the effect of the 'learning from experience' group on clinical governance within a primary care trust (PCT).

Setting Lincolnshire South West PCT.

Results An holistic approach was taken to consider how suggestions, complaints, near misses, risks and incidents can improve organisational learning from adverse events and lead to a more effective clinical governance system for the primary care team. This was a case study and as such relates the experience of one PCT.

Conclusions This approach to a systematised learning experience from adverse events could be of value for other primary care organisations. Replication of this process in other organisations may rely on key individuals being committed to the learning process.

Keywords: case study, clinical governance, complaints, learning from experience, risk management

Introduction

Clinical governance has been described as:

> a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence of clinical care will flourish.[1]

This case study describes how a 'learning from experience group' (LEG) evolved within Lincolnshire South West Teaching PCT (primary care trust). It outlines the reasoning and drivers for the formation of the group and shows how it provided a framework where clinical governance could become more effective. It discusses how the group worked and highlights real situations to demonstrate its value. Clinical governance should underpin everything that is happening within a PCT and the LEG reflected the relevance of this.

While the PCT was collecting a lot of data relating to clinical governance such as risk reports, incident reports and complaints, these were all being dealt with in departmental silos, meaning that several departments could have been dealing with similar issues, unaware that other people were doing likewise.

The clinical governance lead realised that an opportunity was being missed, and proposed to bring all this learning together so that problems and potential problems could be considered holistically. This paper describes this process and considers the pitfalls as well as highlighting the benefits that were gained.

Methods

A case study methodology was used to investigate how the LEG evolved and to show how it supported clinical governance within the PCT. A case study approach is suitable for understanding organisational processes and can be undertaken by gathering data from a variety of methods.[2] It takes a snapshot at a moment in time and allows us to build up a picture showing how things have developed. While this methodology is not generalisable, it does allow others both to benefit from the learning and to consider using similar ideas for their own organisations.

Interviews and discussions were held with the people who had been fundamental to the development of the LEG of South West Lincolnshire PCT and with others who had joined the group in its formative stages. More information was gained from minutes of the LEG meetings. This information was then collated and written, and the draft paper shared with the members of the LEG to ensure that the report accurately reflected what happened.

Results

The kernel of the idea for the LEG was an existing clinical risk group, which was already meeting to discuss risks and take appropriate action; this was running successfully. It was then decided to feed complaints into this process as the realisation grew that the two could be interlinked. Following on from this, occasional group meetings were called on an *ad hoc* and reactive basis, when complaints had been received or issues raised that were felt to need action from more than one party; often this was so informal as to be done almost by discussion in a corridor.

The Health Bill had put the responsibility for efficient effective services – the accountability – firmly into the hands of the chief executives, and with clinical governance on everyone's horizons the various people involved in these meetings realised that here was an opportunity to work towards improving the PCT's accountability.[1] On some occasions one person would raise a topic that others were already dealing with, and over time they identified that those things that were previously being dismissed as 'one offs' or 'unimportant' were gaining higher precedence as evidence was appearing from other departments.

Because these meetings were currently being called in a reactive way, post-incident rather than proactively, it was suggested that the formation of a proactive group to share knowledge could reduce risks and complaints, while helping provide a safer environment for staff and patients. It was realised that in order to effectively learn we needed to pull together all the various systems and the organisational knowledge; consequently the clinical governance manager, with the agreement of the relevant parties, set up the LEG. Its aim was to provide a forum within the teaching PCT to maximise sharing and learning opportunities and reflect on patients' and staff experiences in the form of: feedback, trends and issues from Patient Advice and Liaison Services (PALS), complaints, incidents, external events and patient surveys.

The membership was discussed, to find the most appropriate people for the task; the Commission for Health Improvement had been a driver to forming this group and it was realised that patient involvement was necessary. There was a view that it was impossible for one patient to have a sufficiently broad depth of knowledge on the varied topics that might arise, so it was decided to ask the public engagement manager to attend on behalf of the patient group. She does this and then feeds back filtered information, in order to protect individual staff members' identity, to the patient engagement group who also feed back to the LEG via the public engagement manager.

It was felt that the group needed to have kudos and influence within the organisation and so a non-executive board member agreed to join. The group also includes an associate director of clinical governance/risk manager (chair), public engagement manager, complaints manager, assistant complaints manager, workforce development manager, PALS co-ordinator (on a quarterly basis), risk administrator and service development facilitator. Other managers and clinical leads attend on an *ad hoc* basis to discuss specific items.

The purpose of the group was:

- to receive patient, public and staff information and ensure learning points are shared across the organisation
- to review, monitor and examine complaints, serious untoward incidents, adverse incidents, claims, issues raised by PALS, and issues from national incidents
- to refer issues to appropriate managers for further investigation and necessary action
- improve complaints and incidents handling throughout the organisation by ensuring appropriate training is in place
- responsibility for involving the public engagement group, workforce development group and clinical audit group in the production of the monthly learning from experience report
- to feed back to the public, patients and staff how the teaching PCT has learned from experiences.

Group reporting structure

The LEG reported to the clinical governance committee, the risk management committee and the trust board.

Much discussion was held about where the results of the process needed to be sent, as in many instances there were national as well as local procedures to be followed. Eventually the appropriate process was agreed and the following framework shown in Figure 1 adopted.

The group met monthly and looked at all complaints, all calls to PALS, all incidents, and any other things considered relevant, for example the Shipman report, national guidelines and National Patient Safety Agency (NPSA) patient safety alerts. At the meeting issues were discussed, and the group specifically looked for trends; they then reported back to the relevant parties.

Following identification of a problem, the LEG might have asked for more information and/or worked out a plan of action for themselves, or they may have identified a lead person like a service manager to investigate; this method of working was found to be extremely effective. One example of its usefulness was when it identified that there was a cluster of needlestick injuries to staff, and the trigger for this piece of work was a claim.

Two separate clusters of incidents were highlighted for investigation by the LEG:

1 needlestick injuries to staff: here the investigating team consisted of the infection control nurse, the occupational health nurse and the assistant clinical governance manager
2 disposal problem with potential injury to contractor: here the team was bigger, including the general manager of the adult services, the clinical lead for podiatry, the facilities officer (clinics), the primary care development manager and the assistant clinical governance manager.

From the first problem they identified four separate areas for learning:

- *staff* were not always adhering to the policy
- *training* was not mandatory and not well attended
- *policy*: with staff not always aware of policy
- *patient*: with unpredictability of patients.

From the second problem again there were four separate areas for learning:

- *people* were unfamiliar with local policy as they were employed outside the PCT
- *training/skills* as sharps were being disposed of by staff who had not received training
- *policy* as the guidance was not easily accessible

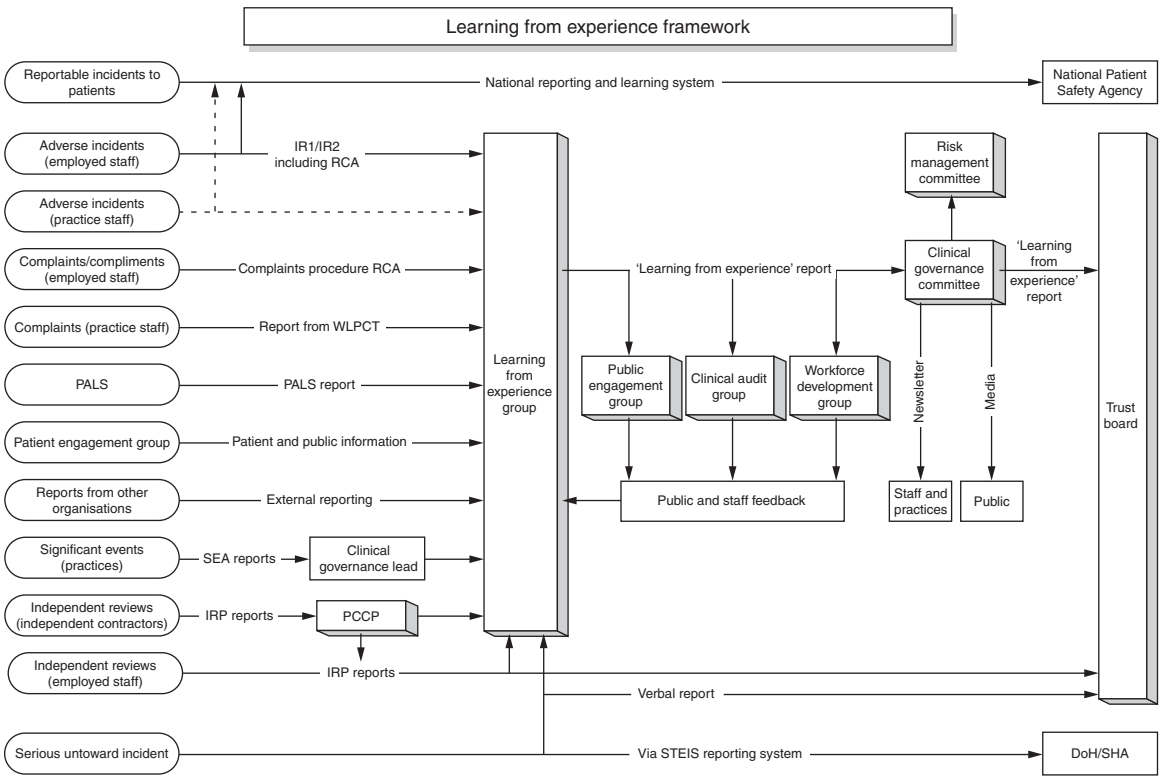

Figure 1 Learning from experience framework. DoH, Department of Health; IR, incident report; IRP, independent reviews; PCCP, primary care clinical performance; RCA, route cause analysis; SEA, significant event audit; SHA, strategic health authority

- *resources* as sharps bins were difficult to assemble, with different bins in all areas and a lack of familiarity. Some bulk waste storage areas were not secure.

The action taken for problem one was as follows:

- *people*: the sharps management section of the infection control manual was reviewed and amended
- *training/skills*: the sharps management training is to be included in induction and in mandatory updates
- *resources*: a poster was devised and circulated for display in clinical areas, diary inserts were provided for appropriate staff, a risk alert was sent to all staff.

The action taken for the second problem was:

- *people*: review of the role of non-clinical staff in handling sharps
- *resources*: sharps bins disposal was reviewed, specialist equipment for blade removal to be designed, one type of bin to be ordered across all areas, site visits to investigate security of clinical waste storage across the PCT
- *policy*: guidance to be reviewed and made more accessible to all users of premises, and the contract with waste disposal contractors to be reviewed.

Another more recent problem was with drug dispensing, which resulted in a pharmacy alert being issued. A patient was prescribed Largactil; however only half the quantity prescribed was available, so the patient's relative went back to collect the remainder the next day. She was given Lamictal, which was side by side on a shelf that was alphabetically arranged; Lamictal was also in similar packaging to Largactil. The sticky label with the correct name was put on the packet over the actual drug name. On investigation it transpired that the dispenser had been distracted in mid-prescription, which is a problem that can occur in busy pharmacies. Following this an alert has now been put on the shelf to identify a potential for error and the problem has been brought to the attention of all pharmacies. The event was also reported to the NPSA so that the learning can be shared nationwide.

Learning and feedback from the LEG goes to all individuals involved and to the 'improving working lives', patient engagement and the clinical governance groups. Where appropriate it goes to national agencies and the minutes are accessible to all within the PCT. The clinical governance committee has been impressed with the way this system works and feels it integrates information and helps to reduce risk.

More recently there has been less 'high-level' commitment to the group as national drivers, such as PCT reconfiguration, take over directors' time. This has led some members of the group to feel that its power has been diminished, and meetings are not happening as regularly as before. Nevertheless the group does continue to carry out the important task of pulling together the many learning opportunities that are happening, and is supporting the PCT towards effective clinical governance.

Conclusion

This model of 'learning from experience' is one that could be usefully used by other health organisations; it helps identify trends in a more timely way and provides a proactive approach to clinical governance.

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CONFLICTS OF INTEREST

None.

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