Clinical governance in action

Clinical governance: a system

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ABSTRACT

Since its inception, the subject of clinical governance has produced a vast amount of literature which has given rise to various interpretations of its role and function.

This has often led to fragmented pieces of work to produce performance indicators, evidence for visits from standards agencies, satisfaction surveys, etc.

Clinical governance has been seen by some as a framework, an agenda or a strategy.

The authors would contend that it is none of these but that it is a system which covers all the necessary processes involved in providing a service which moves patients with wants and needs through to being satisfied patients.

The system is designed to be an iterative process which allows opportunities for ongoing change and improvement.

Keywords: clinical governance, literature review, systems approach

Introduction

Since the 1980s, a variety of approaches have been used to improve the quality of healthcare in the UK, resulting in the current emphasis on clinical governance. Clinical governance is described as a 'framework through which NHS organisations are accountable for continually improving the quality of their services, safeguarding high standards by creating an environment in which excellence in clinical care can flourish'.[1]

However, there is anecdotal evidence that for many parts of the NHS, implementation of clinical governance is problematic and not readily understood. For example, there is a perception that clinical governance is concerned with everything; therefore everything and anything can be construed as having a clinical governance dimension. Additionally, NHS organisations are often required to react to government initiatives, and these will shift the focus of quality activity from time to time.

NHS organisations are asked to produce a clinical governance strategy and to have clinical governance programmes, and there is much talk about the clinical governance agenda. This paper introduces the concept that clinical governance is none of that, that it is not individual initiatives, but is an all-pervading iterative system.

Fieldwork

The authors undertook a review of work being undertaken in a large part of a primary care trust (PCT), between July and October 2002, which was described as clinical governance. It was clear that there were many good pieces of work being carried out. For instance the authors had no difficulty in finding examples of integrated care pathways, audits, significant event analysis and standard setting.

However, in most places, the individual pieces of good work remained just that – individual pieces of work. Often it was unclear why a particular piece of work had been carried out in preference to another. On a number of occasions a piece of work had been hurriedly pulled together as a response to the latest government initiative. This was particularly true in relation to satisfaction surveys undertaken to meet the

recommendations and directives of the government's patient and public involvement initiatives.

From this review the various activities undertaken in the name of clinical governance therefore did not appear to be properly linked or connected, and this led to a lack of understanding amongst staff as to where the piece of work they had been involved with fitted in.

Before and during this review period the authors had been aware of being frequently asked to define clinical governance. In the absence of a one-line response, the often quoted definition, attributed to Sam Galbraith, of 'corporate responsibility for clinical performance' was not generally helpful to staff.[2]

However the concept of corporate responsibility raises issues around corporate sharing of information and a possible mechanism for doing this is described by Baker *et al*.[3]

Literature review

It was with this background that a literature search was undertaken in an attempt to develop a definition of clinical governance, which would be readily understood, encompass all the activities represented as clinical governance, and demonstrate how these linked together.

The Department of Health description of clinical governance given in the introduction to this paper guided the literature search towards continual improvement and creating an environment where excellence can flourish.

The relationship between quality and business objectives has been gradually realised through numerous surveys.[4] Various researchers such as Bright and Cooper, and Higginson and Waxler had reached similar conclusions, that an organisation's culture is a critical factor in achieving quality.[5,6] However, other researchers such as Ford *et al* found that culture could be a barrier to change, especially concerning quality initiatives.[7]

Bettinger in his work identified 12 key components of organisational culture; among them were attitude to change, openness, communication and supervision, and commitment and teamwork.[8]

Nicholson *et al* and Lewis found that there was a relationship between performance attainment and attitude to communication and organisational changes.[9,10]

Various quality initiatives have been applied in the NHS according to Joss and Kogan, and Stahr.[11,12] These have included Resource Management, Clinical Audit, Evidence Based Medicine, Patient Focused Care, Investors In People, Controls Assurance, *The NHS Plan and Working Lives*, ISO 9000, The European Foundation for Quality Management (EFQM), and Total Quality Management. Joss and Kogan offer a comparison of the most widely used initiatives.[11]

Based on various research findings, Herbert, Hore and Smith all found that there seemed to be three models for looking at quality improvement or quality management systems.[13–15] These were The King's Fund Organisational Audit Programme (KFOA), the European Foundation for Quality Management (EFQM) and ISO 9000.

KFOA has been heavily criticised for the volume of paperwork involved and its lack of a systematic approach. The KFOA-implied assumption is the system will first do no harm, whilst Donabedian contends that the 'actual consequence of care in any given instance may prove to be disastrous, quality must be judged as good care if the care at the time it was given, conformed to the practice that could be expected to achieve the best results'.[16]

EFQM has an advantage with a self-assessment tool and allows benchmarking, while ISO 9000 has been in use in the NHS for more than a decade, and has been reported as having achieved great success.[17] However, ISO 9000 has also been frequently criticised as being biased towards a manufacturing environment. This criticism has been largely addressed in the version of ISO 9000 that was published in 2000.

Development of the system

In order to develop a system, which meets the many requirements placed on NHS organisations under the general heading of clinical governance, the authors kept a record of the types of work they were asked to support within their roles as clinical governance staff within a large PCT. The authors also considered the range of topics which government circulars encompassed, where there was a clinical governance implication, together with reviews in their own trust, clinical governance strategies and work programmes.

The authors then compared these types of activities with each of the systems as described in KFOA, EFQM and ISO 9000 2000. What was found was that none of these models could be fitted perfectly to the issues identified around clinical governance, but that the ISO model, with some borrowing from EFQM, did fit.

This still presented the difficulty that the language used in both of these models is generic, and not readily understandable to staff. The authors then attempted to distil the system into a format, which would be more readily understood. Given that ISO 9000 commends the use of flow charting, it was decided to represent a clinical governance system as a flow chart (see Figure 1).
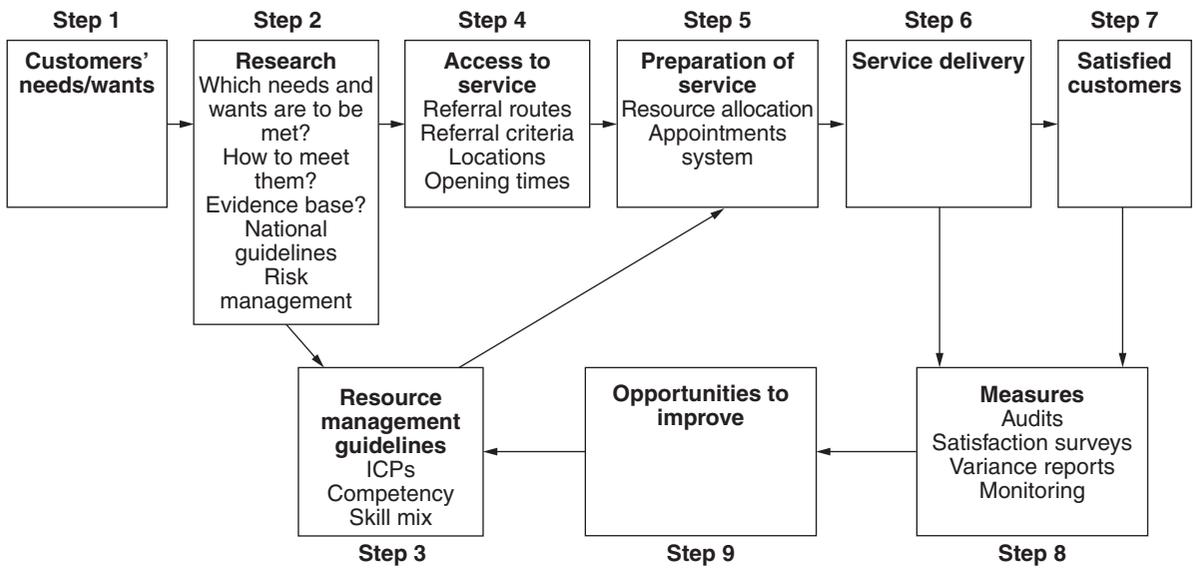
Figure 1 Systems diagram

The figure represents a series of steps to be taken to move people through the service, by starting (**Step 1**) with their needs and wants, and aiming to produce satisfied patients. The chart shows the relationship between the various types of activity, and demonstrates what the authors contend should be an iterative system.

Step 2

There must be a process by which the organisation, or parts of the organisation, assesses the demands that will be placed on their service, and which of these they will respond to. This will include public involvement, which is in line with current national directives. Organisations must also decide how they are going to respond including what evidence bases and national standards will inform their service delivery. Risk management also sits in this box, since there should be a process involved which considers the risks associated with not implementing researched findings and deciding not to conform to a particular evidence base. Part of risk management leads into the next box, which is about controls or resources required in delivering the service.

Step 3

This activity needs to be followed with a set of steps to ensure evidence bases are converted to competencies, assessment tools, integrated care pathways, local guidelines or protocols as required. There must be processes to identify how key specialist competencies

can be accessed. Also in this box are processes relating to equipment availability including maintenance and calibration.

Step 4

People using the service must have a way of accessing the service. The processes here are around referral criteria, screening, and how referrals are dealt with. These processes should be informed by research, to help decisions about how and when the service should be available, what information is available about the new referral and who can supply it, and so on. This is the step called 'access to services'.

Step 5

The next step is called 'preparation of service'. These are the processes by which resources and patients are brought together, and will include bed allocation, appointment systems, accessing specialist equipment, ensuring that staff with the correct skills and competencies are allocated to the patient, and so on.

Step 6

Once the patient and the correct resources have been brought together, the most important aspect of the service, service delivery takes place.

Step 7

There is also a need to measure patient perception of the service encounter – the patient satisfaction box.

Processes here will include satisfaction surveys, complaints procedures, comment cards and so on.

Step 8

After, or while the service is being delivered, the service can be measured to see if it is line with the intended service delivery (the measures box). This requires another set of processes, such as audit, significant event analysis and statistical process control (SPC), which is a widely recognised tool which remains little used in healthcare, despite the fine work outlining healthcare applications by Carey and Lloyd.[18] As many have remarked, what is not measured cannot be managed. What can be clearly seen from the flow chart is that what should be measured ought to be derived from the activities in the research and resource management step.

Step 9

The last box in the system is 'opportunities to improve', and this is what drives continual improvement. This box will contain the processes by which information from the service measurement box and patient satisfaction box are converted to action plans to improve the service. Typically, activities such as root cause analysis and the various problem-solving methodologies would be in this box. This box has been linked back to the resource management box because many action plans will require a change of practice, of equipment or a modification to a protocol.

Finally, the process is intended to be repeated at regular intervals. This is because the starting point is likely to change. The demand for a particular service may change, the expectations of patients may change, and the evidence base or national standards may change.

For illustrative purposes a worked diagram of how a general practice might use the systems approach to deal with implementing a flu vaccine programme is included as Figure 2.

Discussion

The problem with regarding clinical governance or quality as a programme, or a project is that programmes and projects have starts and ends and many projects do not actually demonstrate end results.[19] This is wrong, because clinical governance has no start and no end. Elements of clinical governance have been in place everywhere for years, and ought to continue for years.

Nor is clinical governance an agenda. An agenda has items, which shift up and down in order of importance. People react to what is at the top of the agenda at any point in time. Clinical governance is about a set of interlinked processes that are interdependent. Therefore no one activity has precedence over others at any point in time.

A strategy can be defined as 'the rationale for how the business is going to achieve its purpose'.[20] There is a clear delineation here which enables us to say we have a strategic approach to achieving satisfied patients, and the strategy is to have a systems approach to delivering clinical governance. The rationale for how the business is to achieve its purpose is for the business to have a system of delivery. It is the
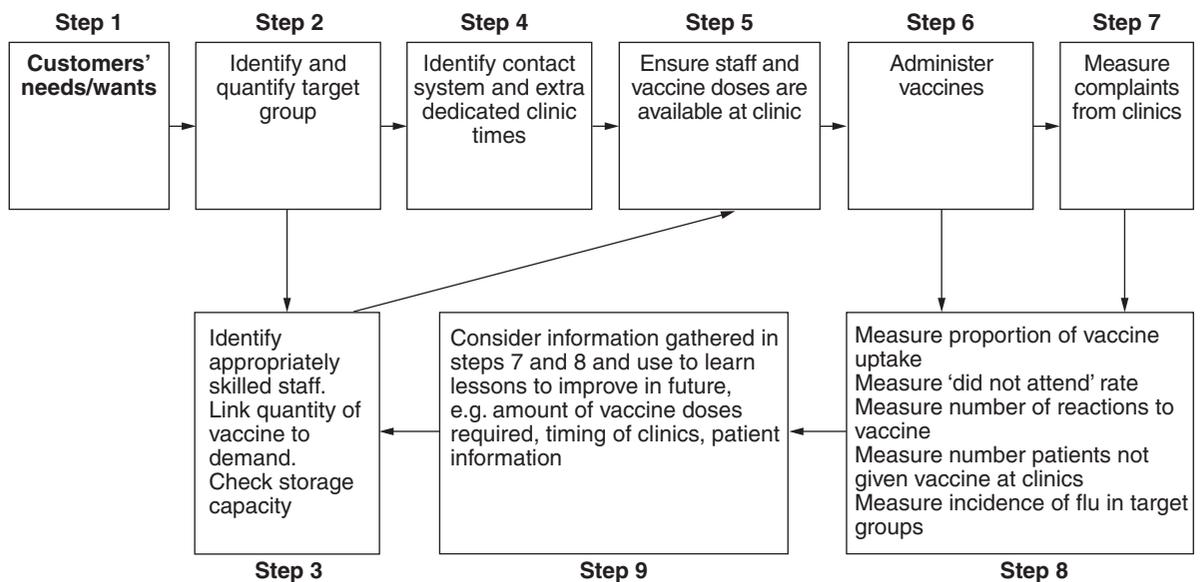

Figure 2 Systems diagram for flu vaccine programme

system, which becomes the vehicle for delivering the purpose.

The systems approach fits in well with Deming's plea that a 'plan, do, check, act cycle' is at the heart of business with steps 1–5 being planning activities, step 6 equates to 'do', steps 7 and 8 are the 'check', and step 9 is 'act'.[21]

Since developing the systems approach described here, it has been presented at workshops and informally within workplaces. The settings include day hospitals, inpatient settings, a general practice, community nursing services, clinics, and a trust property services department. The feedback has been positive. Most areas where this has been presented have chosen to implement such a systems approach. There are early reports of much clearer understanding of what clinical governance entails, and how to demonstrate that clinical governance is being delivered.

This model is offered as an aid to understanding and implementing clinical governance. The model no doubt can be refined. However, one of the strengths of it is that, as a high-level process map, there is real flexibility about how different parts of the NHS fill each of the boxes, with what is right for them.

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CONFLICTS OF INTEREST

None.

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