Clinical governance: another name for quality — or improving on improvement?

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Clinical governance is one of the current crop of ‘buzz terms’ in the quality world. It may be new, but is it useful? And what does it really mean for those who work at the many and varied levels of the Australian healthcare system?

How did clinical governance emerge?

The term ‘clinical governance’ was originally coined by the National Health Service (NHS) in the United Kingdom, and arose from the Bristol Royal Infirmary Inquiry, where one of the key contributing issues identified was the lack of a clear chain of accountability for the quality of clinical care. The NHS defines clinical governance as:

... a framework through which 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 (NHS, as cited in Douglas, Davies et al. 2003).

This concept and definition soon migrated to Australia, and in 2002 it was introduced within state health systems via various policy, legislative and educational means. The Australian Safety and Quality Council also picked it up and quoted it in publications and presentations. The need for clinical governance in Australia was reinforced through public inquiries into Australian health services such as the Royal Melbourne Hospital, King Edward Memorial Hospital and Macarthur Health Service, and a process to adapt the NHS definition to these Australian contexts began.

There has been some confusion at health service level about how clinical governance translates into practice. Isn’t the NHS definition really just talking about an organisation-wide quality program? Don’t we already have these? In some ways, this definition highlights the fact that organisation-wide quality programs have not been the norm in the UK in the same way that they have been in Australia. In 1986 the Australian Council on Healthcare Standards (ACHS) made organisation-wide quality programs, comprising elements such as a quality plan, leadership and pursuing the quality cycle, a formal requirement for accreditation. Most Australian health services undertaking ACHS accreditation since then have developed some form of quality program, and the need for this has been reinforced by the advent of community and health professional concerns about the safety of healthcare, prompted in particular by information emanating from the Quality in Australian Health Care Study in 1995 (Wilson, Runciman et al. 1995).

The effectiveness and credibility of these programs varies considerably, however. There are many reasons for such variability, but a cornerstone issue appears to be the level of priority placed on the program by the governing body and the executive staff. This is where clinical governance, adapted to an Australian context, can build stronger and better quality programs.

What is clinical governance?

In essence, clinical governance is the ‘quality’ component of corporate governance, as it applies to healthcare. It means that health service governing bodies and executives assume the same ultimate responsibility for the oversight of the safety and quality of clinical care (clinical governance) as they do for financial and business outcomes (corporate governance). This means that boards and governing bodies need to ensure that they have the same knowledge of quality matters as they do of financial matters. This will include a number of requirements: that system checks and balances be in place to monitor and manage risks; that they receive regular reports on key areas of priority and risk; that staff accountability for monitoring and improving safety and quality is clearly delineated and supported; and that they have an accurate picture of issues and problems in healthcare and how they are being addressed.

The element of clinical governance that enables it to build on and enhance a quality program is accountability. Definition of and support for clear roles and responsibilities in monitoring and improving quality, from ‘board to bedside’, have long been problematic in quality programs. Such accountabilities are the basis for clinical governance. ACHS has ‘Australianised’ the NHS definition with this in mind, rephrasing it as follows: ‘clinical governance is the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care’ (ACHS 2004).

Minimum requirements for an effective clinical governance program

Due to state-based differences in the way health services are funded and governed, there is no single clinical governance model that fits all circumstances. There are some core principles that should underpin all clinical governance, however, and whatever approach is taken, a clinical governance-based model of safety and quality improvement will demonstrate some standard features across all organisations.

As a minimum requirement, governing bodies and executive staff should ensure that safety and quality management receives the same emphasis as financial management, and is linked to strategic and business planning processes. An effective safety and quality program, underpinned by clinical governance, requires a planned approach wherein governing bodies and executive staff ensure:
• there are appropriate organisational structures, processes and resources in place to monitor, manage and improve the safety of care and services and the service delivery environment

• the objectives of the quality program are clear and staff at all levels understand their related roles and responsibilities

• staff have access to appropriate safety and quality technical support and information to enable their effective participation in improving care and services

• consumers and carers are involved in safety and quality improvement in a variety of ways, including through feedback, complaints and improvement activities

• key areas of risk are identified, prioritised, managed and regularly reported

• there is a strategy for managing those internationally recognised problem areas in patient safety and quality such as health service-acquired infection, medication errors, pressure ulcers, falls, use of blood and blood products and pain management, including regular reporting, action and follow-up

• there is a clear and transparent process for the review of deaths and reporting and responding to sentinel and adverse events

• patient care is based on best available evidence and delivered by properly credentialed and trained staff

• external reviews, such as accreditation, are used as positive opportunities to review compliance with standards

• the health service benchmarks with other like organisations on key areas of care and safety to facilitate learning and improvement

• clinicians lead improvements in clinical care and safety

• there is ongoing development of an organisational culture wherein participation and leadership in safety and quality improvement are resourced, supported, recognised and rewarded. (Victorian Quality Council 2003).

The Manager’s role

What does all this mean for Health Information Managers as department managers and in other specialist roles? A quality program built on a clinical governance foundation places clear accountabilities for implementation throughout the organisation. On an operational level, it is up to the CEO and managers to make it easier for staff at all levels of the organisation to do the right thing in the provision and improvement of quality care and services. Research has shown that there are three key predictors of staff involvement in safety and quality activities:

• the extent of support from their direct line manager

• a belief that the organisation will experience outcomes of value from the activities

• training in the tools of change and improvement.

Thus, embedding the improvement program in an organisation will require engaging and building leaders and innovators at all levels, from ‘board to bedside’, with managers having a critical role in turning clinical governance policy into practice. Strong leadership at all levels of the organisation is the foundation of an effective safety and quality improvement program. It requires the CEO and senior managers to clearly delineate and support all managers’ responsibilities for improving safety and quality as part of position descriptions and performance reviews. Managers, in turn, must fulfill those responsibilities through enabling and encouraging their staff to actively improve safety and quality. In short, managers play a critical safety and quality leadership role, and clinical governance actively supports and promulgates this by:

• espousing and enacting commitment to clinical governance by their attitude to, and involvement in, safety and quality issues

• seeking education and information to equip themselves to lead the safety and quality program

• participating in the development and evaluation of a safety and quality plan and structure which involves consumers and clinical and opinion leaders, to monitor, improve and respond to the safety and quality of care and services

• empowering accountable staff at all levels and holding them responsible for being appropriately involved in monitoring and improving care and services

• providing planning, infrastructure and resources for the collection, reporting and benchmarking of valid, reliable and relevant safety and quality data

• ensuring systems are in place to facilitate safe, quality care, including the application of best available evidence and learning from problems experienced within the organisation and in other health services and systems

• ensuring all staff are clear about the principles and practices of safety and quality by providing information, education and technical support, and holding senior staff accountable for modelling desired behaviour and practices

• fostering a culture which does not blame, but rather seeks to solve problems and learn from them and support staff in this process

• establishing open information exchange with consumers and the wider community in relation to issues of clinical error and problems and achievements in service delivery

• acting on recommendations where problems with quality are apparent via events or data monitoring

• ensuring staff are trained and empowered to respond appropriately to adverse events

• providing data and information to the peak quality committee and Board relevant to their role, and to the Department of Human Services and other relevant organisations as appropriate.

Clinical governance, with its focus on clear responsibilities, has also helped clarify the role of the quality manager. Responsibility for staff participation in safety and quality cannot lie with the quality manager and other associated personnel. The quality manager can and should assist with encouraging staff involvement as a technical expert, for example, ensuring staff are trained and equipped to participate, setting up appropriate monitoring and reporting systems and providing guidance with planning, executing and evaluating ac-
Information management — a key to effective clinical governance

One of the difficulties in addressing quality management with the same interest and rigour as financial management is the lack of robust universal systems for collecting and reporting on key areas of quality and risk. The minimum requirements for effective clinical governance emphasise the critical role of information management, and this is something with which many governing bodies, executives and clinical and non-clinical managers continue to struggle. In this context, information management refers to data collection, the technology required for this function, the reliability and validity of this data, and the means by which data are reported and converted into information. Health information skills can make an invaluable contribution to this process through provision of advice on available data, design of extraction and reporting systems, and analysis of data to assist in setting priorities for monitoring and improvement.

All health services should agree upon a minimum dataset of high-risk issues to be regularly reported throughout the organisation, and health information managers are uniquely placed to advise on this. To support safe, high quality care and services, data and information should be available, accurate, timely and relevant. These criteria can be ensured by means of review of coding accuracy, robust data definitions and collection systems, and transparent and streamlined analysis and reporting processes.

Those with health information-related expertise can also advise on other minimum requirements of an effective clinical governance-driven quality program, such as constructive use of the accreditation process and subsequent findings, design and participation in quality and clinical review processes, and advice on benchmarking and evidence-based practice.

The verdict

The answer to the question posed in the title of this article appears to be that clinical governance does improve on improvement. You can take the clinical governance out of the quality program, but you can’t take the quality program out of clinical governance! It is eminently possible to run an organisation-wide quality program in healthcare without a foundation of clinical governance; we have been doing this in Australia for many years. These programs were often run by a few committed people who were driven by a belief in continuous improvement, or by the requirement or desire to be accredited. Whilst the energy and enthusiasm inherent in this approach are admirable, it is neither organisationally comprehensive nor sustainable.

Clinical governance is a foundation for building more meaningful, useful and sustainable quality programs. When implemented effectively, clinical governance helps to mainstream quality and to highlight safety as a key component of patient care. It places importance and priority on the quality program as a critical part of organisational functioning, and resources it accordingly. Responsibility for managing risks and making improvements is spread across the organisation. People are held accountable for their role in this, and trained to fulfil that role. The importance of organisational culture is recognised and addressed to reduce blame and embed excellence. It redefines the quality manager role as one of technical expert, neither responsible for the levels of participation of all staff in quality activities, nor shouldering the bulk of the burden of achieving accreditation.

Different Australian states are addressing clinical governance in various ways, as is the norm in our complex Australian healthcare system. You will notice different definitions, terminology and implementation processes across the states. Despite this, effective clinical governance will display the common theme of high level organisational interest and commitment that flows around the organisation as systematic and practical strategies to enhance involvement in, and outcomes of, your current quality programs.

And that is an improvement on improvement.

References


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