

Clinical Governance: A Practical Guide

Introduction

When the government's White Paper *The New NHS. Modern. Dependable.* (Dept of Health 1997) descended on to clinicians' desks, few had a clear understanding of the meaning of clinical governance, let alone the scope of the project. Now this phrase is part of the everyday parlance of the health service. The weight of words written on the subject is remarkable, as different groups from the NHS Executive to the Royal Colleges to academic bodies have sought to make sense of clinical governance. So why more words on this subject?

This guide takes as fundamental the proposition that **clinical governance is everybody's business** (NHS Executive 1998a: 31). While the multitude of documents produced on clinical governance have implicitly acknowledged this, most have been highly abstract, and divorced from the realities of practice. Check lists, action points, proposed timetables for implementation have been developed for action by 'leads' for clinical governance in trusts or the new primary care organisations (henceforth, PCOs). Little has been written which illustrates the importance of clinical governance for the majority of people who work in the health service, the clinicians, the technical and ancillary staff: the general practitioner and the practice nurse who – ultimately – will be the making or breaking of clinical governance.

The new Primary Care Organisations (PCOs)

NHS White Papers and associated health service circulars have established different primary care umbrella organisations in different parts of the UK. In England, primary care groups (PCGs) co-ordinate care across a number of general practices, and may in time become primary care trusts (PCTs). Similar organisations in Wales are known as Local Health Groups (LHGs). In Scotland, Local Health Care Commissioning groups (LHCCs) have power to commission care from hospital trusts. The organisation of primary care in Northern Ireland is yet to be confirmed.

Maybe it's not so surprising that this gap has yet to be filled. As yet, little has been required of trusts and PCOs: in each of these organisations a clinical governance lead has been appointed and a committee established to address the programme for the establishment of clinical governance. The year 2000 marks the deadline for the first report on clinical governance in a trust or PCO, and the proposed monitoring visits to trusts and PCOs are still some years in the future. The programme to establish clinical governance -- to ensure fair access to high quality care throughout the NHS -- is a long-term strategy with a time scale of up to ten years for its implementation.

So it is timely to show the relevance, the importance and the centrality of clinical governance for everyone who has anything to do with patient care. Because, without this involvement, clinical governance will become no more than a cosmetic exercise, a chore which will comprise little more than an annual report of achievements and a gloss on shortcomings.

This guide will unpack clinical governance, and fashion an approach to governance based on clinical realities, taking as the starting point, and the finishing line, and for that matter everything in between, the excellence in health care which is the only logic for clinical governance. More formally, the objectives are that, having worked through this guide, a reader will be able to:

- Offer arguments for a commitment to continuing quality improvement in delivering a service to patients;
- Suggest ways in which s/he can contribute to clinical governance in her/his everyday activity, be it as clinician, manager or clinical governance lead;
- Identify areas for personal and professional development which can enhance her/his capacity to contribute to the clinical governance of health care in her/his arena of responsibility.

Using this guide

To address the objectives identified above, this guide has intentionally included an interactive element. Of course, readers may choose to treat it like a text, which

supplies the answers with little effort other than a quick skim. But they may also find it helpful to reflect on the points raised, applying these to their own situation. To this end, there are a number of **reflective exercises** built in to the text. These can be used in a number of ways:

- Individually, consider the reflective point, and write down your thoughts on what has been argued in the section of the guide.
- As a group, or in a workshop, use the exercise to focus on the needs of either the individual clinician, or the organisation more generally. For example, a workshop could consider the professional development needs of the PCO or trust, or a clinical governance sub-committee could develop a response to a problem of under-performance in a constituent unit of the PCO/trust.
- Alternatively the individual reflections might be collated as a preparatory exercise prior to some kind of organisational initiative such as a workshop to explore issues in the clinical governance of a PCO or trust. Or they could be used as a means for a clinical governance lead to start the dissemination of the culture of clinical governance throughout her/his organisation.

In addition to these exercises, the final part of this guide includes a further interactive element. It is geared to assist readers to identify priorities for implementing clinical governance processes, related to the skills already available within their organisation, and those which can be quickly obtained through continuing professional development and educational programmes.

Mid-air governance

There are one or two well-known definitions of clinical governance which are usually trotted out at the start of discussions on the subject. If you want to check these definitions out now, look at the note at the end of the guide. (1) But, to get to grips with what clinical governance entails, consider the following analogy.

Imagine that you are taking a flight with your favourite airline, or maybe your favourite can't supply the flight you need, so you have taken another carrier which

serves your intended destination. Either way, you hope to have an uneventful flight and arrive safely.

Apart from a ticket and boarding pass, a receipt for checked baggage, the safety leaflet and maybe a menu for the in-flight meals in the seat pocket, it is unlikely that you will have other documents pertaining to the flight, and particularly the safety standards of the plane. But you would expect such documentation to exist, and that bodies such as the UK Civil Aviation Authority would be regularly checking this out. The kinds of thing you could expect to be available might include:

- Certification of airworthiness, and documents about the commissioning of the airplane into service, safety checks and maintenance records;
- Conformance to industry and legal standards, both for the airplane itself and such issues as working hours, conditions of work and safety regulations (for instance, ensuring pilots are not inebriated);
- Documents concerning the training of the crew, including both initial and in-service training (for example around safety procedures and competencies such as language the skills to communicate to air traffic controllers and knowledge of terminology), and information on procedures to ensure skills are regularly updated;
- Manuals and other guidelines for staff, both for routine matters and for emergency situations
- Adequate strategic management procedures to ensure quality of all aspects of the flight, including policies on risk management, clear lines of responsibility for safety, and processes of accountability for errors. It might also involve details of business planning: the insolvent or loss-making airline is unlikely to be as safe as the one which is well capitalised.

Passengers would hardly wish to have to wade through all this material before taking their seats. But the expectation that these guarantees of safety procedures both exist and are seen by a regulator within a process of audit will reassure you about the likelihood of a safe journey. (You might also be encouraged by the more nebulous

sense that the airline's employees are motivated and enthusiastic about their work, though this in itself would not guarantee safety in the absence of other processes.)

This analogy should illustrate some important features of governance, both of an airplane journey and of a health service. First, though safety cannot ever be guaranteed one hundred per cent, benchmarking quality of products, processes and activities against **high standards** will minimise risk.

Second, governance procedures are intended not to correct errors after they happen, but to avoid them happening in the first place. This means a commitment to **continuous quality improvement**.

Third, the successful outcome of an activity (a flight, an episode of treatment of a patient) depends on a myriad of interlocking factors, and **requires participation in quality procedures by everybody**. The flight attendant who has forgotten the safety drill endangers emergency procedures even if everyone else plays their part effectively. The lack of adequate supervision of a junior doctor can be the weak link in the chain. (The responsibility of the passenger or the patient for her/his own actions may also be acknowledged here: **users** have a part to play in assuring the safety or quality of an activity, and must be involved in quality assurance procedures.)

Finally, the governance of an activity depends not only upon having systems of quality assurance in place, but also that these **systems can be demonstrated** to be in place and effective. Governance, by demonstrating quality to a regulator on behalf of 'the public' releases individual passengers or patients from the onerous task of evaluating the procedures employed by an airline or health service before using it. As such, governance is a marker of responsibility or **accountability** for the quality of service, and as such may be considered central to the professional and ethical obligation which a provider has to her/his client.

Perhaps the most valuable lesson from this analogy between health care and air travel is that the kinds of governance which are being proposed for health services are taken for granted in other areas. Indeed we would be horrified if such procedures did not exist for a hazardous business like flying aboard a commercial airplane. Health care,

which can have life or death significance for its consumers, surely deserves the kind of governance which we expect elsewhere.

Clinical Governance: What's the Point

The pathfinder definition of clinical governance, which appears in *A First Class Service* (NHS Executive 1998b), identifies the key elements of clinical governance.

Clinical governance is:

‘... 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’ (my emphases).

The first important point is that clinical governance comprises a series of **interlocking processes** which together contribute the outcome of governance of health care. We will look at the process elements which are part of this framework later in this guide. It follows that clinical governance is an outcome, rather than an act in its own right: only if all the constituent elements are in place, will we achieve clinical governance.

The three key components of clinical governance thus are:

- A system of **accountability** and responsibility (by organisations, but we might add, individual clinicians also). Within the clinical governance framework, chief executive officers (CEOs) of trusts (and health authorities on behalf of their PCOs) are ultimately accountable for the clinical activities and quality of care in their organisation. To make such accountability workable, the basic structure of a clinical governance lead (a clinician) and a sub-committee will take responsibility for ensuring quality and that standards are met. They will report to the Board of the trust or PCO, and contribute to the annual clinical governance report. The accountability of the CEO goes hand-in-hand with the responsibility all clinicians have for delivering excellent care.

- A commitment to **continuous quality improvement (CQI)** in the delivery and management of health care. It is not sufficient to meet a target and then sit back on one's laurels. CQI entails the continual aspiration to surpass targets and then identify higher standards for service delivery. CQI depends on excellent professional and personal skills, interprofessional team working and continuing professional development. It means that standards will steadily rise across the NHS.
- A system for ensuring **standards** are set and met (for example through risk management and the management of performance). Standards are defined by combining available research evidence on clinical effectiveness, clinical expertise and patient and user feedback. Meeting standards depends on having effective systems of audit of clinical activity; where they are not met, action plans for improvement and re-audit are implemented. Setting national standards reduces variation in service delivery.

Finally, clinical governance has as its objective **excellence** in the delivery of clinical care. This is the only rationale for clinical governance: it is not an end in itself, nor a management exercise to rationalise use of resources or staffing (although, as will be indicated in the next section, clinical governance could be used in these ways). This framework is illustrated in Figure 1.

Figure 1: The elements of clinical governance.



So what's the point of clinical governance? To answer that question, imagine ten years into the future, when – guess what – the NHS has been transformed by the system of clinical governance! Here is a case study; a patient who belongs to Somewhere Medical Centre, part of the Anywhere primary care trust (PCT).

Mr A is a 55 year old married man with a history of breathlessness, hypertension and occasional mild angina, who exhibits several risk factors for coronary heart disease (CHD). Three months ago he was prescribed prophylactic statins (lipid-lowering medication) after a full work-up by Dr B in the primary care setting. He is attending for his three monthly check up with the practice nurse at Somewhere Medical Centre. On examination and interview, Mr A is responding well to the prescribed medication, his symptoms have reduced and his blood pressure has lowered significantly.

Firstly, considering the management of Mr A's condition, we can see that:

- Dr B, the general practitioner, has followed the most recent National Service Framework for management of CHD in primary care, as set out in a May 2003 circular, and locally produced guidelines from Anywhere PCT. These guidelines were developed following a risk management exercise, taking into account the local circumstances surrounding referrals into secondary care and resource allocation.
- Before prescribing statins to her patients, Dr B had consulted a database of research evidence on clinical trials of these drugs available from the National Institute for Clinical Excellence, using her NHSnet connection. She is also able to use this to participate in an electronic forum on CHD which includes cardiology specialists and primary care clinicians
- The use of the Electronic Patient Record enables confidential sharing of information across the PCT (every clinician has a networked PC on her/his desk). Mr A's data automatically contributes to the clinical audit of management of CHD in primary care being undertaken by the Trust as part of its continuing effort to improve its service delivery in this and a number of other key areas.
- These data are included in the annual clinical governance report by the PCT. The data are also used to benchmark the PCT against equivalent Trusts, and to increase

its standards for the stable management of CHD year on year. In one or two cases in the past, it has also been used to identify clinicians who were under-performing in certain areas, to enable remedial education and support. Last year, the Commission for Health Improvement visited the PCT as part of a rolling programme of external monitoring. This routinely gathered data informed the documentation prepared for the CHI visitation.

Other circumstances pertinent to this case study:

- Dr B has undertaken a course in the management of CHD in primary care as part of her re-accreditation process. All members of the PCT staff have annual appraisals which identify needs for continuing professional development (CPD) and continuing medical education (CME). There is protected time for staff to undertake CPD, CME and other courses. Dr B studies part-time for a Master's degree, and human resource planning provides flexible work patterns to enable access to education and training.
- Over the past ten years, three members of the PCT Board, including the Chief Executive, the Chair and a nurse member have gained MBA qualifications by part-time study at the local University. They are facilitating a series of workshops on risk management and performance management to snowball their knowledge and skills across the PCT.
- Somewhere Medical Centre clinicians hold case conferences each month at which staff reports critical incidents. Teambuilding workshops have contributed to a no-blame culture in which errors and variations in service delivery can be aired openly. Each incident is subjected to review to improve processes of service delivery. The review is documented and shared across the PCT using the trust's intranet (an electronic communication network within an organisation).
- Staff participate in 'quality circles' which cut across traditional hierarchies and encourage initiatives from all those involved with patient care, including reception and administrative staff. One proposal from a quality circle meant that Mr A was able to book his appointment via the Internet, enabling him to plan his work schedule around it.
- Mr A was part of a focus group of patients from across the PCT who were consulted about service delivery in the trust. Reports from these consultations are

considered by the clinical governance sub-committee, and included in the sub-committee's report to the PCT Board.

- The PCT has employed an information officer who can undertake Medline searches for research data for clinical staff, both to support clinical activity and as part of research studies being undertaken by a number of staff members. The information officer also manages the intranet and offers IM&T training and advice. He is responsible for collating data routinely collected during clinical work, to inform the annual reports and internal reviews of performance. He is line managed by the clinical governance lead for the PCT.

A little bit too perfect? Well maybe, but the case illustrates my argument that clinical governance is not a single process, but comprises a range of activities, all of which have the patient, and the excellence of service delivery at their heart. We can see the key elements here:

- **Accountability:** the information management systems and case conferences, appraisal system and mechanisms for addressing under-performance make all clinicians and the organisation accountable for the quality of service delivered. Annual reports on quality enable transparency of quality of care. There is expertise in management skills which is being disseminated throughout the PCT.
- **Continuous Quality Improvement:** a culture of quality improvement, openness about errors and variability in service, user involvement, quality circles and programmes for CME and CPD enable standards for quality in care to be continually surpassed and raised. These processes are underpinned by excellent information management systems. Collaboration with Health Improvement Programmes (HImPs) enables quality improvements to be co-ordinated locally and across the NHS.
- **Safeguarding high standards:** care is delivered according to National Service Frameworks where these exist, and within the context of evidence-based practice and locally-developed guidelines on disease management, which include risk assessment. Quality of service delivery and internal systems and processes are audited and benchmarked against appropriate organisations, and responsiveness to under-performance through flexible workforce strategies and continuing education

programmes minimise variation in quality. Clinical governance annual reports and the Commission for Health Improvement visits monitor standards.

And the bottom line? Excellence in care is the point of these interlocking and inter-dependent systems and processes. Mr A is receiving **excellent** care, but this cannot be put down to one element. It is the consequence of processes which assure high standards are met, continually improve on those standards and accept responsibility for quality service delivery.

Reflective Points 1 and 2

1. Why do proponents of Continuous Quality Improvement (CQI) talk about reducing variability? Surely medicine is an uncertain and variable business?
2. List the processes enabling clinical governance identified in the case study above which are already in place (even if they need a little tweaking) in your organisation. You can use this list to help identify action points later in the guide.

What clinical governance is not

Having broken down the definition of clinical governance, and then built it up again through the case study of Mr A, the logic of clinical governance should be clear. But before moving on to look at some components of clinical governance in greater detail, let us return for one moment to the analogy with an airplane journey, to conduct a 'risk assessment' on clinical governance itself. Risk assessment is an important part of any planning process, to see what could go wrong, and help protect against avoidable mistakes.

It should now be possible to recognise the congruence between the systems which might assure a high standard of safety on an airplane flight, and the kind of quality assurance which Mr A's care reflects. But a cynic might see the documentation of

safety procedures on a flight as most useful *after* an airplane crash! Certainly, they would be extremely valuable to the airline’s solicitors at the compensation hearing, to justify their safety record and shift the blame elsewhere.

But that is not the point of governance. Governance is not intended as a means of justification after an undesirable outcome, it is intended to prevent an outcome being undesirable. It is concerned with quality *assurance* not quality *control*. No doubt it can (and perhaps will) be used sometimes as a *post hoc* validation, but the spirit of clinical governance is in the other direction.

Clinical governance can and should be used positively, and -- with the commitment of all clinicians -- it can deliver its objective of assuring excellence in patient care. But there are associated risks, which derive from clinical governance’s capacity to be subverted in a variety of ways. It is worth setting out some of the positive characteristics of clinical governance and associated risks. If we are aware of the ways in which the spirit of clinical governance can be upended, we can ensure that it does not become just another fad or fashion, to be derided as no more than a management tool. Box 1 makes some comparisons between what clinical governance should and should not be.

Box 1: Two approaches to clinical governance

| Clinical governance should not be: | Clinical governance should be: |
|---|---|
| A system for responding to errors, or for justifying errors as unforeseeable | A system for assuring quality and avoiding errors/reducing variations |
| A top-down exercise, taken on by a clinical governance lead in each unit | An activity in which all staff are actively involved, under the leadership of a designated and accountable individual |
| An extra task to be undertaken alongside clinical or managerial duties | Integral to the everyday activities of clinicians, managers and other staff |
| A low priority activity which attempts to whitewash over the cracks in the ‘real business’ of treating patients | A high priority activity which clinicians recognise enables excellent care to be delivered uniformly across the NHS |

| | |
|--|---|
| A yearly management exercise resulting in a report on a trust/PCO's quality activities | A process (like an audit cycle) of review, planning, action, showing and sharing |
| A system requiring an entire new system of internal monitoring | Built on systems which are already in place and can be adapted and expanded to achieve clinical governance |
| A means of 'shaming and blaming' under-performing individuals or units | A means to encourage openness about errors and a commitment to work collaboratively and across the NHS to improve service |
| An erosion of self-regulation | A way of encouraging a culture of accountability among all clinicians |
| Something which is achieved once-and-for-all, and is thereafter set in stone | A developmental process which is responsive to changing circumstances |
| Tagged on to existing organisational arrangements in the NHS | Consequent upon a culture shift in the NHS, based on the principles on this side of the table. |

The right hand side of this table is thus a wish-list for clinical governance, the left-hand side is a list of risks – subversions of clinical governance which will undermine and destroy its rationale and its capacity to deliver excellence of care.

The NHS Executive's advice on the implementation of clinical governance is doing a good job in promoting the right hand version, but the roll-out of clinical governance depends on the people in trusts and PCOs, and it is upon this that it will stand or fail. This list of contrasts reminds us first that clinical governance requires a cultural change, and also that clinical governance is everybody's business. The success of clinical governance depends on the involvement of all, and upon skills in the **management of change** among those responsible for ensuring the culture of the NHS is in line with the principles of clinical governance. With that in mind, spend a few minutes on the following reflection.

Reflective Point 3

Think about the positive and negative directions in which clinical governance could develop. Identify three actions in your organisation which would ensure clinical governance develops in a positive direction.

1.

2.

3.

Why clinical governance now?

Clinical governance has not dropped from the sky, it can be seen in the particular context of the NHS and efforts to introduce reforms. Neither is it a new concept: it builds on earlier conceptions of quality management, including audit and clinical guidelines.

The context of clinical governance

The 1991 reforms of the NHS introduced a quasi-market economy into the service, separating purchasing and provision roles, and establishing competition through the system of hospital and community trusts and fund-holding general practices. The belief behind this set of reforms was that the market would supply the motor for efficiency in a public service by mimicking a commercial sector organisation. While no doubt contributing so some savings in resources, these measures threw up anomalies, notably the rationing of health care and geographical and other inequities in access to care.

While in opposition, the Labour Party had indicated its ideological rejection of the market regulation of the NHS. But by rejecting the discipline of the market as a tool for efficiency and effectiveness, they were forced -- on taking power in 1997 -- to look elsewhere for a mechanism for improving standards.

Meanwhile, a series of highly publicised incidents in clinical malpractice, most recently the case of paediatric surgery at the Bristol Royal Infirmary, and mounting costs of litigation, suggested that clinical risk management and clinical audit mechanisms were inadequate.

Responding to the context: continuous quality improvement

The focus within clinical governance upon **continuous quality improvement (CQI)** and quality assurance draws on a well-established and contemporary perspective in management science which has a proven track record in both private and public sectors. Quality assurance seeks to reduce variations in a product or service, rather than responding to failures. CQI is based on organisational strategies which involve all members of staff in efforts to consider how to improve their contribution to the organisation's output.

Clinical governance also builds on principles of **corporate governance**, which addresses issues of accountability in the running of organisations. These two bodies of theory together offer a mechanism for quality assurance in health care delivery which:

- a) provide a means to address **equity** across an organisation comprising many constituent units, while also setting in train processes to assure **value-for-money** in a service provided at tax-payers' expense
- b) expands the concept of **accountability** from the corporate level to the level of clinical operations
- c) incorporates **clinical risk management** into the quality process, linking risk reduction to CQI.
- d) Addresses issues of **performance management** which assure standards are achieved.

The CQI emphasis in clinical governance builds on **clinical audit**, which is relatively well-established in the NHS, but adding a fourth stage of showing and sharing to the three stages of standard setting, service monitoring and implementing improvements. Most of the national initiatives announced in *A First Class Service* such as the NICE and the National Service Frameworks are concerned with standard-setting, extensions

of efforts to establish **clinical guidelines**, while the clinical governance activities are devolved to NHS constituent units.

(***Note to sub-editor: box content ends here)

The National Infrastructure

Some of the national initiatives which have been launched to support clinical governance and the quality push in the NHS have already been mentioned. While these elements of national infrastructure are fairly well documented in NHS Executive publications (e.g. NHS Executive 1998b, 1999), it is helpful to bring these together in a single list, to see how they contribute to clinical governance.

There is one principal new resource which will support **excellence** in health care delivery, and a public health initiative to address key areas for **CQI**:

National Institute for Clinical Excellence (NICE)

The NICE has been conceived as providing the knowledge base for an evidence-based approach to clinical care, to promote treatments and therapeutics which are both clinically and cost effective. It will draw on the databases developed by such organisations as the Cochrane Collaboration and the NHS Centre for Reviews and Dissemination (which gather and disseminate research studies and reviews of research into health care interventions), and a broad range of expertise including clinicians, managers and patients. NICE will assess new and existing interventions, and develop evidence-based guidelines to assist clinicians to apply effective technologies. It will be supported by the NELH (see below).

Health Improvement Programmes (HIImP)

Health Improvement Plans are specific multi-agency interventions co-ordinated by health authorities. Their aim is to improve the health of a particular community, and reduce inequalities, usually in terms of a limited number of disease categories such as coronary heart disease or mental health. HIImPs will draw on public health data from a locality; PCOs will be involved not only in terms of contributing to this data

collection, but also as front-line staff in implementing the HImP, in collaboration with other agencies such as Social Services and community trusts.

Standard setting will be achieved through a number of new bodies which will inform the quality of service which should be delivered across the NHS:

National Service Frameworks (NSFs)

NSFs set out what patients may expect to receive from the NHS in major care areas. They define best practice, and set standards for care delivery in these areas of service delivery. At the time of writing, four NSFs have been announced, in the areas of coronary heart disease, diabetes, mental health, and the care of older people. NSFs will address what have been seen as unacceptable variations in care quality across the UK in the past. As time passes, the NSFs for different conditions will become more stringent, so that standards will be raised progressively higher.

National Performance Framework

This is intended to provide comparative information on performance in similar organisations. For example, hospitals will be compared on a range of indicators for certain elective procedures or following admissions for conditions such as myocardial infarction. Data will be published on six key areas:

- Health improvement
- Fair access to services
- Effective delivery of care
- Efficiency
- Patient and carer experience
- Health outcomes of NHS care

Efforts will be made to ensure the validity of indicators of comparison, for example, by adjusting for confounding variables. Based on these comparisons, the framework will seek to identify areas where questions need to be asked about performance issues.

National Patient and User Survey

An annual survey of patient and users will provide feedback on the range of experiences which users have, from clinical care to the quality of hospital catering.

This will contribute to the data on comparisons between different parts of the NHS, and according to *A First Class Service* (NHS Executive 1998b) could trigger an intervention by the Commission for Health Improvement (q.v.) where a trust is under-performing.

A new **monitoring** body provides the 'teeth' in the clinical governance process:

Commission for Health Improvement (CHI)

This is a new statutory body providing an independent assessment of how parts of the NHS are faring in quality improvement and clinical governance. It will visit all trusts and PCTs (PCOs, which will be assessed via health authorities) to ensure clinical governance is in place and that NICE guidance is consistently implemented. It will act as a trouble-shooter where there are serious problems over quality assurance, and *in extremis*, may be sent into a trust to take urgent remedial action.

The NHS information management infrastructure is also important for clinical governance:

National Electronic Library for Health (NELH)

The NELH is still in its infancy, but will provide a means of easy access by NHS staff to research evidence and best current knowledge, including the outputs of the NICE. It may also have a role in providing a resource bank of continuing professional development materials. The NELH is being organised into 'sub-branches' including one for primary care. The 'building site' for the primary care NELH can be accessed via the Internet at the following address.

<http://drsdesk.sghms.ac.uk/NeLH-PC/index.htm>

NHSnet and Information Management and Technology (IM&T) Strategy

The NHSnet is an intranet for the entire NHS, providing a secure means of electronic communication across the service, and access to resources such as Medline.

Secondary care trust management and health authorities are already connected to NHSnet; clinicians in primary care will have NHSnet connections by the end of 2000, and most secondary care clinicians by 2002. The NHSnet will enable the innovation of an **electronic patient record**, which will enable patient information to be

transferred across the NHS securely. The NHSnet also provides access to the Internet, enabling NHS staff to use the resources available world-wide.

Information management is probably the one area where there is a major need for resource development to achieve clinical governance. This is both in terms of hardware (computers, networking etc) but also human resources, in the shape of people with the necessary skills to apply information management techniques to a range of activities. The new Information for Health strategy document (Department of Health 1998) identifies a wide range of skills in information management which will be required by NHS staff to make use of the new information and communication technologies. Each health authority and hospital trust has drawn up a Local Implementation Strategy (LIS) to address this skills roll-out, and a pilot project has been commissioned to explore the educational issues involved in skilling the NHS in information management and technology.

Implementing the Clinical Governance Cycle

By now, you should have a clear idea of what clinical governance is about; the positive features of clinical governance, and what infrastructure and organisations are there to support it. So how to move from this abstracted model to the concrete reality of achieving clinical governance in a PCO or trust?

Earlier in this guide, we identified the three key elements of clinical governance, which we unpacked from the pathfinder definition: accountability, continuous quality improvement (CQI), and standard setting. These three elements were discussed earlier, but as a review point, jot down the relevance of each for clinical governance.

Reflective Point 4

In the achievement of clinical governance,

1. Accountability is important because ...

2. Continuous Quality Improvement is important because ...

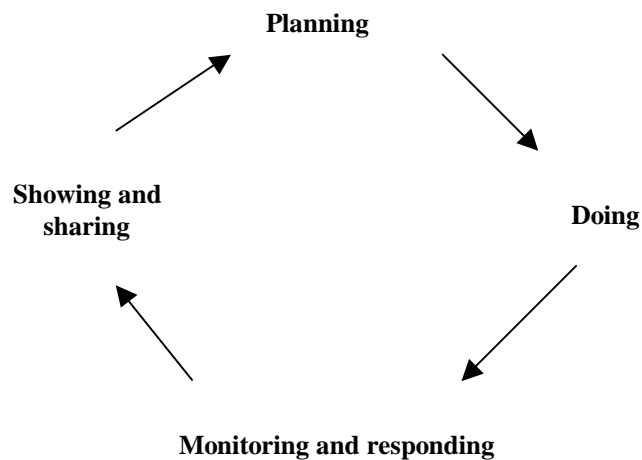
3. Standard setting is important because ...

If you were not certain about any of these, check back now.

We can start to think about the implementation of clinical governance from the idea that it is something which is *achieved*. While there are various *processes* involved in clinical governance, it is itself in a sense an *outcome*, something which is either in place or is not. Knowing what is needed in terms of processes is the first step, however, clinical governance is achieved by the establishment of a **cycle** in which the stages of review and documentation are crucially important. Specifically, it is not enough to be doing quality assurance, one needs to be **seen to be doing it**. (2) At the moment the cycle is closed, clinical governance is achieved, and not before: if the cycle is disrupted in any way, clinical governance is lost. This can be illustrated in Figure 2. Descriptively, the stages are:

| | |
|---------------------------------------|---|
| Planning and setting standards | Agree objectives, benchmark against guidelines or research evidence, establish the process, make it explicit in the organisation through communication networks |
| Doing | Process implemented, including mechanism for data collection and audit |
| Monitoring and responding | Set criteria for audit, collect data, compare against standard, formulate and implement action plan to correct errors or variations |
| Showing and sharing | Document cycle and share findings within and beyond the organisation, annual report and external monitoring |

Figure 2. The clinical governance cycle



In this cycle, we can see the three key elements of clinical governance. First, there is an adherence to **standards**, hence the need to benchmark and then measure activity against defined performance indicators. Second, there is the cycle of **continuing quality improvement** which entails monitoring and then responding to errors or variations. Finally, there is the **accountability** built into the showing and sharing phase of the cycle.

As trusts and PCOs begin to implement clinical governance, they will focus on very specific areas, such as the treatment of CHD or cancers. Over time, the elements of care for which there is clinical governance will increase, with the final objective being that all areas of clinical practice are subject to the governance cycle. Fortunately, the process is such that – once established in one clinical area – it will be easily transferable to other areas.

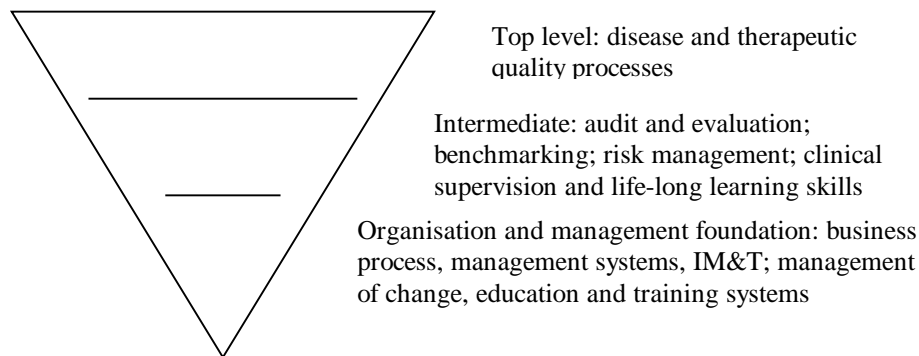
However, as was noted earlier, clinical governance amounts to more than just a glorified audit cycle. Indeed, the logic behind clinical governance is to enable effective audit and quality assurance, as the implementation of audit has been patchy in the past, and often seen as an end in itself, rather than as a mechanism for improvement. Clinical governance entails a cultural change, the purpose of which is to create the conditions under which CQI will result in excellent care. Cultural change is a challenge for PCOs and trusts, and will often require specific new skills and training in change management.

By breaking clinical governance down into its components, and then taking this four-stage model of a cycle of governance, it is possible to detail the precise actions which will be required to fulfil the requirements of clinical governance. The next section supplies a comprehensive analysis of the elements of clinical governance which together enable this cycle of planning, doing, monitoring, and sharing.

Building clinical governance: processes and skills

As has just been noted, clinical governance requires a range of processes, which may be seen as a hierarchy, from specific areas of governance of a disease area or therapeutic intervention, through to the general organisational and developmental processes which underpin the quality of these specific processes. This hierarchy is illustrated in Figure 3.

Figure 3. The hierarchy of clinical governance processes



Within the hierarchy of processes, there is a high degree of inter-dependency, with the underpinning organisation and management process providing the foundations upon which systems for audit, benchmarking and the quality of specific clinical activities rely. For instance, the clinical governance of CHD entails more than just adherence to a set of guidelines. There will be a range of processes involved, including information management procedures for identifying patients at risk, auditing current management of these patients, co-ordinating treatment and follow-up, clinical supervision and training, and the organisational framework to co-ordinate these processes. Similarly, the skills and resources required for the clinical governance of

CHD go beyond clinical knowledge and evidence-based practice, and reflect the span of underpinning processes.

To identify the range of processes which need to be established to achieve clinical governance in a PCO or trust can be done fairly simply, using an analysis of the **critical success factors (CSFs)** and **key interventions** required. At the end of the guide, you will use this tool to identify the priorities for process improvement in your organisation. As an illustration of the use of this technique, let us take a look at two areas of development which will be involved in achieving clinical governance (see table 1). Having identified an area for improvement, the questions to be asked are:

- What are the CSFs required to achieve (and to be seen to achieve) this objective?
- What key interventions will lead to fulfilment of the CSFs?
- What are the resource and training implications of these interventions?

Table 1. Critical Success Factors in areas for improvement

| Area for Improvement | Increasing clinical audit across trust/PCO | Blame-free culture for reporting adverse events in PCO |
|-----------------------------|---|--|
| CSFs | <ol style="list-style-type: none"> 1. Increase the proportion of MAAG/PCAG audits undertaken in the PCO to 60% within 3 years 2. Increase re-audits to 40% in 3 years 3. All clinical staff involved in one or more audits/year 4. Increase audits with user involvement to 20% | <ol style="list-style-type: none"> 1. Weekly minuted case conferences at practice level 2. Reporting cycle for adverse events 3. Review system for implementing best practice |
| Key Interventions | <ol style="list-style-type: none"> 1. Appoint audit lead 2. Training in audit skills 3. Develop IM&T systems 4. Feedback audit results | <ol style="list-style-type: none"> 1. Develop reporting system for adverse events 2. Lead by example in |

| | | |
|-----------------------|---|---|
| | <p>and re-audit successes via intranet</p> <p>5. Release funds for audit</p> <p>6. Establish focus groups of users in key audit areas</p> | <p>case conferencing on critical incidents</p> <p>3. Mentoring system</p> <p>4. Quality circles of peers to discuss practice and quality improvement</p> <p>5. Encourage evidence-based practice in areas where adverse events reported</p> |
| Training Needs | <p>Audit skills</p> <p>IM&T skills</p> <p>Communication</p> | <p>Leadership skills</p> <p>Reflective practice skills</p> <p>Mentoring skills</p> <p>Teambuilding and group-work skills</p> <p>Evidence-based practice skills</p> |
| Resource Needs | <p>Time for training and to undertake audits</p> <p>Information management systems</p> | <p>Time for training and case conferences</p> <p>Administration of case conferences</p> |

These CSF analyses are valuable because they indicate a way forward for actions to establish elements of the clinical governance process. They identify clearly:

- a) The demonstrable outcomes (the CSFs) needed to enable improvement in an area,
- b) The concrete activities (key interventions) which will fulfil the CSFs, and
- c) The training and resource implications of the quality assurance process.

Together they can form an action plan for implementation, with clear actions to achieve the objective.

In the final section of this guide, we return to action planning, with a specific focus on the development work required to implement clinical governance processes. Before that, it will be helpful to identify the entire range of processes which together

comprise the building blocks of clinical governance. As will be seen, this is a fairly substantial list, and the following tables (2 – 5) focus on the key processes, and the skills and resources which will be needed to turn an area for improvement into reality.

We will consider the three elements of clinical governance (accountability, standard-setting and CQI). But as has been acknowledged, clinical governance requires a sea change in organisational culture which requires fundamental changes to organisational processes and systems. Because of this, a fourth analysis is devoted to these foundations.

For each set of processes, the following will be identified:

- a) the key question which has to be answered in relation to this element
- b) the processes needed to achieve the element (which may be transformed into CSFs when action planning)
- c) the skills and resources required to put these processes in place (3).

First, accountability:

Table 2: Processes for Accountability

| Question to be posed | Processes/CSFs | Skills/Resources Needed |
|--|--|---|
| How can we ensure that there is accountability for clinical activity in this organisation? | Lines of responsibility from CEO to clinicians | Strategic thinking; strategic management; human resource management |
| | High quality of data on clinical activity | IM&T skills and systems |
| | Risk management | Change management; risk management; IM&T |
| | Public Involvement | Consultation |
| | Effective leadership | Leadership |
| | Annual report completed | Writing skills |

Table 2 demonstrates that implementing accountability requires a substantial range of skills. Most of these are required by the CEO, PCO chair or clinical governance lead, but in some cases -- like information management – new skills are needed by all clinicians to ensure data quality is high. Most of these skills can be developed relatively easily and can use existing networks for continuing professional development. The main resource required is time for training and implementation, plus systems for information management.

Second, meeting high standards for service delivery:

Table 3: Processes for Meeting High Standards

| Question to be posed | Processes/CSFs | Skills/Resources Needed |
|---|-----------------------------------|--|
| How do we ensure that the service delivery in this organisation meets external standards? | Respond to NSFs, NICE guidelines | Evidence-based practice (EBP) and critical appraisal |
| | Address under-performance | Risk management; decision-making; life-long learning; re-accreditation; remediation, |
| | Complaints system | Administrative system; case conference system |
| | Clinical supervision | Clinical supervision |
| | Clinical risk reduction | Risk management |
| | Clinical and organisational audit | Audit |

Table 3 shows that, once again, there is a substantial range of skills required, and in this case, all clinical staff will require many of these. But again, most can be developed using existing CPD networks. Few additional resources are required other than time for training and implementation.

Third, continuous quality improvement (CQI):

Table 4: Processes for CQI

| Question to be posed | Processes | Skills/Resources Needed |
|--|-------------------------------|--|
| How do we enable continuous improvement in the quality of service delivery in this organisation? | EBP | EBP and critical appraisal |
| | Clinical effectiveness | Specific disease and therapeutic management skills; continuing medical education (CME); protocols and guidelines |
| | Information management | IM&T |
| | Needs assessment | Needs assessment and epidemiology (collaborate with public health dept at health authority) |
| | Research and audit | Research methods and audit |
| | Quality assurance | Quality assurance |
| | Clinical supervision | Clinical supervision; mentoring |
| | Culture of life-long learning | Reflective practice; CPD; professional development planning (PDP) |

Continuous quality improvement is central to clinical governance, and in this key area, unsurprisingly there is a wide range of skills required by all clinicians. Once again, all can be met through CPD and CME, and there is cross-over with the previous key element in terms of skills required. The public health department of the health authority will be crucial in supporting needs assessment, based on the data which they collect on patterns of morbidity and mortality in the CCG or trust catchment area.

The fourth table completes this analysis, focusing on the foundations of general organisational development. These address the fundamental cultural and resource implications of clinical governance.

Table 5: Processes for organisational development

| Question to be posed | Processes | Skills/Resources Needed |
|--|---|---|
| How do we ensure that our organisation is capable of responding to the changes which clinical governance will require? | Organisational development | Strategic management; change management; business process; project management; teamwork and leadership; administrative skills; management software |
| | Personal development | Appraisal and re-accreditation; decision making; team and group working; communication; networking; negotiation; life-long learning and professional development planning (PDP); time and stress management |
| | Information management and data quality | IM&T and knowledge management skills/systems |
| | Infrastructure and resources | Strategic management; human resource management |
| | Culture change | Reflective practice; strategic management |

Table 5 shows the extent of the skills required, both for the management team and for all staff, including non-clinical staff in some cases. There are some high level skills

here (such as strategic management) which may require specific training, but often, recruitment of top management would have been based on acquiring these skills for the organisation. Again, an information management system and the skills to apply it will be essential here.

Clinical governance Skills Analysis

Trying to plan for clinical governance is challenging because it is an apparently complex and high level activity. However, by focusing at the level of skills, it is possible to identify what is required to implement clinical governance. From the four tables developed above, we can create a master matrix, which identifies the skills required for achieving clinical governance. As we have already seen, these skills are often generic, supporting a range of processes required for the success of clinical governance.

We can identify broad categories of skills, which I have called **organisational**, **professional, audit and evaluation**, **clinical update** (including disease-specific and therapeutic skills) and **personal** skills. We can also identify which skills are required by all staff, those needed by some or all clinical staff, and those which are only required by the ‘management’ team (for example, the trust or PCO board, clinical governance leads).

Table 6. A master matrix of clinical governance skills

Key: Skills required by clinical staff •
 Skills required by management •
 Skills required by all •

| | General Organisation Accountability | Standards | CQI |
|-----------------------|---|-----------|-----|
| Organisational Skills | | | |

| | General | Organisation | Accountability | Standards | CQI |
|-----------------------|----------------|---------------------|-----------------------|------------------|------------|
| Strategic management | • | | | | |
| Change management | • | • | | | |
| Business Process | • | | | | |
| Benchmarking | • | | | • | |
| Project management | • | | | | |
| Administrative skills | • | | | | |
| Human Resource man | • | | | | |
| Risk management | • | • | | • | |

| Professional Skills | | | | |
|----------------------------|---|---|---|---|
| Information management | • | • | • | • |
| Quality assurance | • | | | • |
| Appraisal/Mentoring | • | | • | • |
| Public Consultation | • | | | |
| Clinical supervision | | | • | • |
| Negotiation | • | | | |
| Re-accreditation | • | | • | |
| Research methods | • | | | • |

| Audit and Evaluation | | | | |
|-----------------------------|--|--|---|---|
| Critical appraisal | | | • | • |
| Evidence-based practice | | | • | • |
| Clinical audit | | | • | • |
| Needs assessment | | | | • |
| Epidemiology | | | | • |

| Clinical Update Skills | | | | |
|-------------------------------|--|--|---|---|
| Disease-specific CME | | | • | • |

| | | | | |
|----------------------------|--|--|---|---|
| Therapeutic/Product CME | | | • | • |
|----------------------------|--|--|---|---|

| | | | | |
|-------------------------|---|---|---|---|
| Personal Skills | | | | |
| Life-long learning | • | | • | • |
| Communication | • | • | | • |
| Reflective practice/PDP | • | | • | • |
| Decision making | • | • | • | • |
| Leadership | • | • | | |
| Teamwork | • | | • | • |
| Time management | • | | | • |
| Stress management | • | | | • |

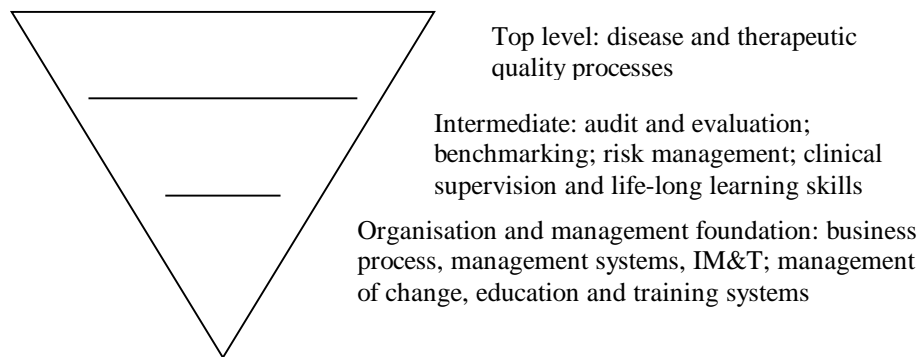
The master matrix provides a check list for skills needed for clinical governance. As you will see, many of these skills are generic, and cover a range of elements of the clinical governance process. Many of the skills are required by specific groups of staff, although some are needed by all – both management and clinicians. In the final sections of this guide, we will use this matrix to develop an action plan for clinical governance implementation.

Clinical Governance: Next Steps and Quick Wins

As will have been seen from what has gone before, the achievement of clinical governance depends upon a series of interlocking processes. These can be unpacked in terms of CSFs and key interventions, and in terms of the skills and additional resources which are required to implement these elements. Together, these audits of processes and associated skills and resources can be applied directly, to identify a way forward in planning a clinical governance programme.

You will recall how clinical governance can be envisaged as a hierarchy of processes ranging from the specific (the top level) to the foundations of organisation and management.

Figure 3. The hierarchy of clinical governance processes



At the 'top' are the 'near-patient' processes which will lead directly to 'excellence' in clinical care: the governance of disease and therapeutic processes. These are concerned with assuring that all clinical activity adheres to agreed standards, and is informed by high quality and up-to-date research evidence. It is based on principles of evidence-based practice and frequent clinical update of skills and knowledge.

The intermediate processes are those which enable the 'top-level' activities to be effective and efficient. They include the use of audit and re-audit cycles to assure clinical effectiveness, benchmarking to provide standards for clinical care, risk management and processes of clinical supervision, mentoring and the use of professional development plans (PDPs) to reduce errors and address under-performance.

The foundations are the organisational and management processes which keep the organisation ticking over, and enable the intermediate and top-level activities to be co-ordinated. They address the foundations of business process (for instance human resource and financial management), information systems and aspects of organisation culture (like the blame-free culture considered in the CSF analysis earlier).

Thinking about clinical governance in terms of this hierarchy of processes, and using the critical success factor analysis used earlier (Table 1) -- enables an organisation to make some quick wins in terms of establishing the framework for clinical governance. First, these analyses untie what is otherwise a Gordian knot of inter-dependent processes. Second, they enable an organisation to build on existing skills and to identify the skills and resources needed before a process can be implemented. To

start this process, please undertake the following reflective exercise, to identify the skills at your organisation's disposal.

Reflective Exercise 5

The master matrix of skills for clinical governance (Table 6) identified the range of skills required for the full implementation of governance. Referring back to table 6, fill in the following table for your organisation or staff group. For each skill, tick *either*:

- a) those already held by appropriate staff
- b) those held by staff, which could be shared or developed to skill appropriate staff in your organisation
- c) those held by staff, but which could not be easily shared or developed without new training
- d) those which are not held by any staff in the organisation or staff group.

This is not necessarily an exercise that you can complete in a minute or two. You may not be fully aware of what skills are available within your organisation: if this the case then tick category d), but acknowledge that some further research is needed for this skills audit. Note also that it is likely that many clinical staff will need disease-specific and therapeutic update in at least some areas.

Table 7. A clinical governance skills audit

| | Skills already developed | Skills which can be transferred | Skills which cannot be transferred easily | Skills entirely missing in the organisation |
|------------------------------|--------------------------|---------------------------------|---|---|
| Organisational Skills | | | | |
| Strategic management | | | | |
| Change management | | | | |
| Benchmarking | | | | |

| | Skills already developed | Skills which can be transferred | Skills which cannot be transferred easily | Skills entirely missing in the organisation |
|-----------------------|---------------------------------|--|--|--|
| Business Process | | | | |
| Project management | | | | |
| Administrative skills | | | | |
| Human Resource man | | | | |
| Risk management | | | | |

| Professional Skills | | | | |
|----------------------------|--|--|--|--|
| Information management | | | | |
| Quality assurance | | | | |
| Appraisal/Mentoring | | | | |
| Public Consultation | | | | |
| Clinical supervision | | | | |
| Negotiation | | | | |
| Re-validation | | | | |
| Research methods | | | | |

| Audit and Evaluation | | | | |
|-----------------------------|--|--|--|--|
| Critical appraisal | | | | |
| Evidence-based practice | | | | |
| Clinical audit | | | | |
| Needs assessment | | | | |
| Epidemiology | | | | |

| Clinical Update Skills | | | | |
|-------------------------------|--|--|--|--|
| Disease-specific skills | | | | |
| Therapeutic/Product skills | | | | |

| | | | | |
|-------------------------|--|--|--|--|
| Personal Skills | | | | |
| Life-long learning | | | | |
| Communication | | | | |
| Reflective practice/PDP | | | | |
| Decision making | | | | |
| Leadership | | | | |
| Teamwork | | | | |
| Time management | | | | |
| Stress management | | | | |

As an *aide-memoire* to yourself at this point, you might just wish to quickly list the skills which you have identified as priorities for training input.

- 1.
- 2.
- 3.
- 4.

This exercise is the first step in identifying what is needed by your trust or PCO in terms of educational development. I will look at some possibilities for accessing this training in the final section.

This is the point at which you can start to think about some quick wins in achieving clinical governance. Although clinical governance is a five- or even ten-year project, we have to start somewhere. This guide has supplied two sets of data which can enable you to start. The **critical success factor analysis** (table 1) illustrated how areas for improvement can be turned into concrete actions, identifying areas for training. Two examples of key processes required in the early years of clinical governance were considered:

- enhancing audit processes
- creating a non-blame culture for adverse events reporting.

The four tables of **clinical governance processes** (tables 2 – 5) identified the processes and related skills and resources needed for each element of clinical governance.

From this position, there are two possible ways to proceed. Either

- a) identify the activities which must be undertaken early in the clinical governance development programme, and the human resource implications in terms of resources and skills, or
- b) cross-match the skills audit you conducted a moment ago with the processes in tables 2 – 5, to identify areas where your organisation is in a good position to start to implement a process with minimal training.

Either way, please conduct two or three CSF analyses. To remind you of the process, here is another one (table 8) which unpacks an activity every organisation in the NHS must complete: the annual report on clinical governance.

Table 8. Critical Success Factors for the Clinical Governance Report

| Area for Improvement | Annual report on clinical governance |
|-----------------------------|---|
| CSFs | <ol style="list-style-type: none"> 1. Report is accurate and contains valid quantitative data on activities 2. Report reflects the extent of actions to implement clinical governance in the organisation (the development plan) 3. Report responds to initiatives such as the HImP and NSFs 4. Report is the outcome of consultation across the organisation, and includes input from users/patients 5. Report language and style is accessible to lay readers 6. Report submitted on schedule |
| Key Interventions | <ol style="list-style-type: none"> 1. Establish responsibility for progressing report preparation 2. Risk assessment for threats to project 3. Identify key areas of the report (check core reporting requirements issued from NHS Executive) and benchmark |

| | |
|------------------------------|---|
| | <p>against similar organisations</p> <ol style="list-style-type: none"> 4. Identify key indicators to be used to inform report (including HImP and NSFs) 5. Establish the validity and reliability of these indicators as operationalised within the organisation (e.g. PACT data, disease registers, accuracy of case conference minutes) 6. Agree time scale for data collection and analysis 7. Implement processes for data collection and analysis, including consultation with organisation staff and users 8. Progress chase data and other materials for report 9. Write report clearly and comprehensively 10. Consult across organisation on draft report 11. Submit report |
| Resource Implications | <ol style="list-style-type: none"> 1. Protected time for report research and preparation 2. Information management systems to gather and organise data, and enable high quality data to be collected |
| Training Needs | <ol style="list-style-type: none"> 1. Strategic thinking and decision-making 2. Writing and publishing skills 3. Benchmarking 4. Risk assessment 5. Time management |

| | |
|--|---|
| | 6. Quantitative data analysis 7. Consultation skills |
|--|---|

Where the resources or the training are not already in place, this provides an immediate indicator of what must be done to assure the report is completed successfully. Select two or three areas for improvement which are going to have the maximum impact on the organisation in the early years of clinical governance. For example:

| | |
|-------------------------------|--|
| Foundation Processes | Information management system for audit Strategic change management |
| Intermediate Processes | Evidence-based practice and critical appraisal Benchmarking Addressing under-performance |
| Top-level Processes | Specific disease and therapeutic quality processes (for example, management of heart disease in primary care, mental health) |

An education and development programme for clinical governance

In concluding this guide to clinical governance, there are a number of key messages which have been emphasised throughout. These all have relevance for the kind of approach which has been developed here, and for the next steps in clinical governance.

Key messages

1. Clinical governance is **everybody's business**: it will founder if it is seen as a management activity
2. Clinical governance is a **long-term strategy requiring cultural change**. The hearts are as important as the minds of staff in this initiative. The human resources of the NHS are central to the success of clinical governance

3. There is a need for **new skills** to achieve clinical governance
4. Many of these skills are **generic**, and will be useful in a range of processes contributing to clinical governance.
5. Many of these skills are the bread and butter of CPD and CME, and should be easily available through **education and training networks**.

The major resources which will carry clinical governance forward are already in place: they are the human resources of the NHS. Some new skills will come from new appointments, but continuing professional development (CPD) has been acknowledged by the NHS Executive (1999) as central to the programme of clinical governance. Organisations must recognise the need for a concerted programme of education and development, and take the steps required to implement this (indeed, this may well be one of the CSF analyses you have undertaken, to identify the key interventions needed to give your staff the right training.) This educational initiative needs to be seen not as a discrete set of actions, but as a rolling programme, within the ethos of life-long learning. But it must not be haphazard. **Clinical governance will depend on the right training being accessed at the right moment.** The CSF analyses can assist in developing this ‘just-in-time’ approach.

Reflective Exercise 6

As a final reflective exercise, based on the priorities you identified in Reflective Exercise 5 and your CSF analyses, identify the areas for training which are crucial for your clinical governance programme over the next two years.

| Time scale | Skills and Knowledge Requirements | Staff to be trained |
|-------------------|--|----------------------------|
| Next 6 months | | |
| Next 12 months | | |
| Next 24 months | | |

| | | |
|--|--|--|
| | | |
|--|--|--|

In terms of delivery of training, there are various networks which can provide educational input, including the Royal Colleges, CPD and CME networks and various other initiatives. A list of contact details appears in Appendix 1.

Conclusion

This guide has provided a framework for turning clinical governance into reality. There is a lot at stake for the NHS in the clinical governance agenda, not least being the effective treatment of patients within a commitment to excellence and continuous quality improvement. A step-by-step approach can break down the complexities of achieving clinical governance, to identify who needs what skills, when and how.

Clinical governance is both a challenge and an opportunity. It offers a perspective on NHS staff as valued and valuable: the essential resource to be cherished and encouraged to flourish. This evaluation sets an agenda in which life-long learning is a cultural imperative, integral to practice, highly prized, and for the many, not the few.

Notes

1. The White Paper *A First Class Service* (Dept of Health 1998) offers the following definition: ‘... 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’. The Royal College of Nursing (1998) offers a cut-down version of this: ‘Clinical governance is a framework which helps all clinicians – including nurses – to continuously improve quality and safeguard standards of care’. North Thames Region NHS (1998a) suggest ‘... the means by which organisations ensure the provision of quality clinical care by making individuals accountable for setting, maintaining and monitoring performance standards.’
2. This analysis is based on Ellis et al (1998), RCN (1998).

3. This section draws upon a number of documents. In addition to the government publications already mentioned, these include an RCN (1998) document *Guidance for Nurses on Clinical Governance*, the NHS (1998c) *Organisational development resource for Primary Care Groups*, and an NHS North Thames (1998b) guide called *Clinical governance in North Thames*.

Acknowledgements

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Bibliography

Department of Health (1997) *The New NHS. Modern. Dependable*. London: Stationery Office.

Department of Health (1998) *Information for Health*. London: DoH.

Ellis J et al (1998) *Framework for Implementing Clinical Governance*. Sheffield: NHS Trent Policy Development Office.

NHS Executive (1998a) *An Organisational Development Resource for Primary Care Groups*. London: Department of Health.

NHS Executive (1998b) *A First Class Service. Quality in the NHS*. London: Department of Health.

NHS Executive (1998c) *An Organisational Development Resource for Primary Care Groups*. London: Department of Health

NHS Executive (1999) *Clinical Governance. Quality in the new NHS*. London: Department of Health.

North Thames Region NHS Executive (1998a) *Clinical Governance in North Thames and London. The role of the Health Authority in clinical governance*. Leeds: NHS Executive.

North Thames Region NHS Executive (1998b) *Clinical Governance in North Thames*. Leeds: NHS Executive.

Royal College of Nursing (1998) *Guidance for Nurses on Clinical governance*.
London.

Further reading/resources

- Baker R, Lakhani M, Fraser R, Cheater F (1999) 'A model for clinical governance in primary care groups', *British Medical Journal*, **318**: 779-783
- Black, N (1998) 'Clinical governance: fine words or action?' *British Medical Journal*, **316**: 297-298
- Donaldson LJ (1998) 'Clinical governance: a statutory duty for quality improvement', *Journal of Epidemiology & Community Health*, **52**: 73-4
- Edwards J, Packham R (1999) 'A model for the practical implementation of clinical governance', *Journal of Clinical Effectiveness*, **1**: 13-18.
- Fox NJ (1999) 'Educating for clinical governance: how can the Internet help?' Available at <http://www.shef.ac.uk/uni/projects/wrp/cgcentre.html>
- Gulland A. (1999) 'What is clinical governance?' *Nursing Times*, **95**: 17
- Miller B (1999) 'Carry that weight [clinical governance and chief executives]', *Health Service Journal*, (18 Feb 1999), 22-7
- Rimmer J (1998) 'The Commission for Health Improvement. An opportunity or a threat?' *Audit Trends*, **6**: 83-85
- Scally G, Donaldson LJ (1998) 'The NHS's 50th anniversary. Clinical governance and the drive for quality improvement in the new NHS in England', *British Medical Journal*, **317**: 61-5
- Thomson R. (1998) 'Quality to the fore in health policy - at last. But the NHS mustn't encourage quality improvement with punitive approaches', *British Medical Journal*, **317**: 95-6
- Wilson J (1998) 'Clinical governance', *British Journal of Nursing*, **7**: 987-988
- The WISDOM Centre for Networked Learning runs a virtual conference on clinical governance and has a web site with many resources for clinical governance. It can be found on the Internet at <http://www.wisdom.org.uk>

Appendix 1 Training and Education Organisations

British Association of Medical Managers

Organises training packages to suit individual organisations. Details from: Joanne Mayes, British Association of Medical Managers, Third Floor, Petersgate House, Petersgate St, Stockport SK1 1HE. Tel: (0161) 474 1141, fax: (0161) 474 7167

Clinical Governance Support Service

Focuses on mental health issues, and is run as a network, facilitating contact and discussion between NHS trusts. It also produces a quarterly bibliography of guidelines, systematic reviews and abstracts in mental health. Enquiries to: Victoria Thomas, Royal College of Psychiatrists Research Unit, 11 Grosvenor Crescent, London SW1X 7EE. Tel: 0171 235 2351, fax: 0171 235 2954

Healthcare Events

Healthcare Events organise a rolling programme of conferences on clinical governance, clinical effectiveness and improving clinical practice. Contact: Healthcare Events, 12-50 Kingsgate Road, Kingston, Surrey KT2 5AA. Tel: (0181) 408 5234, fax: (0181) 408 5434.

Healthcare Quality Quest

Healthcare Quality Quest provide a range of courses in clinical governance, changing clinical practice, clinical audit and clinical effectiveness. Contact: Christine Allam, Healthcare Quality Quest, Shelley Farm, Shelley Lane, Ower, Romsey, Hampshire SO51 6AS. Tel: 01703 814024, fax: 01703 814020.

Healthcare Risk Resources International

HRRI offers an organisational approach to improving quality of care, placing special emphasis on the need to reduce errors and their costs. They also produce a quarterly journal: *Healthcare Risk Resource*. Contact: The Healthcare Risk Resource, 4th Floor, 40 Limes Street, London EC3M 5EA. Tel: (0171) 220 7890, fax: (0171) 220 7891.

Institute of Health Service Managers

The Institute's web site includes access to *Clinical Governance Briefing*. The Institute publishes *Health Management*, a monthly journal for health managers. Contact:

Institute of Health Service Managers, 7-10 Chandos Street, London W1M 9DE. Tel: (0171) 460 7654, fax (0171) 460 7655, web site: <http://www.ihsm.co.uk/>

The Northern and Yorkshire Evidence-Based Practice Group

For information about workshops and other activities, contact: Dr Toby Lipman, Westerhope Medical Group, 377 Stamfordham Road, Newcastle upon Tyne NE5 2LH. Tel. 0191 243 7000.

Royal College of General Practitioners

Active in local areas in provision of CME. Has published a book entitled *Clinical Governance: practical advice for primary care in England and Wales*. Contact: Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU. Tel (0171) 581 3232, fax (0171) 225 3047

Royal College of Nursing

Contact: Judith Jones, Dynamic Quality Improvement Programme (DQI), Royal College of Nursing, 20 Cavendish Square, London W1M 0AB.

WISDOM Centre for Networked Learning

Offers comprehensive training in a range of clinical governance skills, including change management, evidence based practice, information management, research and life-long learning skills. Can provide scoping workshops for PCOs and trusts on clinical governance. Contact: Dr Alan O'Rourke, Community Sciences Centre, Northern General Hospital, Sheffield S5 7AU. Tel: 0114 271 5095, fax 0114 243 3762, e-mail a.j.orourke@sheffield.ac.uk, web site: <http://www.wisdom.org.uk>