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ESSENTIAL NOTES

What is clinical governance?

A.J.R. Macfarlane[1,2]

[1]Glasgow Royal Infirmary, Glasgow, UK and [2]University of Glasgow, Glasgow, UK

alan.macfarlane@nhs.net

Clinical governance may be defined as 'the framework through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high quality of care'.[1] Improving quality should be a core value of healthcare institutions worldwide; indeed, following the Health Care Act 1999 there is a statutory 'duty of quality' for healthcare providers in the UK.[2] Several clinical governance 'frameworks' or 'pillars' exist, but all focus ultimately on delivering safe, effective, and person-centred care to *every* patient, *all of the time*. This article aims to provide an introduction to clinical governance and is based on UK practice.

In NHS organisations, the chief executive has overall responsibility for clinical governance. Each hospital has a clinical governance lead (often the medical director) and depending on the size and structure of the organisation, governance may be configured into several multidisciplinary tiers. UK Anaesthesia Clinical Services Accreditation (ACSA) standards mandate that every department of anaesthesia should have a clinical governance lead.[3] Generally, anaesthesia governance meetings would include as a minimum the clinical director and senior managerial and nursing staff. Leadership is required to ensure that clinical governance processes are embedded within service provision.

Safe care

Several methods are used to safeguard patients' care, and systems to minimise and manage risk should be in place.[4] When problems are identified, or occur, there needs to be an open, transparent, and blame-free reporting system. The goal is to understand the issue and allow lessons to be learned, shared, and acted upon constructively in order to prevent recurrence. Organisations that manage risk effectively and efficiently are more likely to achieve safe and effective care.[5]

Incident reporting

An *incident* is any event or circumstance that led to unintended or unexpected harm, loss, or damage. A *near miss* is an event or occurrence which, but for skilful management or a fortunate turn of events, would have led to harm, loss, or damage. Most incidents can be investigated locally: the seniority of the investigating team depends on the severity of the incident. A *significant incident* is an event sufficiently serious to warrant a formal root cause analysis investigation and usually involves death or serious injury/ill health, major damage to property, loss of a service, a major health risk, or a threat to the strategic objective(s) of the organisation. In England, these must be reported via the Strategic Executive Information System but also via the National Reporting and Learning system (NRLS) if patient safety is involved. The recent UK Duty of Candour legislation requires that every healthcare professional must be open, honest, and supportive when a patient suffers as a result of treatment received.[6] An apology and support should be offered, and an explanation that there will be an investigation (by definition usually a significant incident investigation) after which the results will be shared. A *never event* is a serious incident that in theory is wholly preventable, because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented.[7] In England, these must be reported via the NRLS. Sharing of lessons learned from other incidents through the RCoA Safe Anaesthesia Liaison Group (SALG) is voluntary. Meaningful safety recommendations relevant to anaesthesia and critical care have also emerged from the recently formed Healthcare Safety Investigation Branch. Finally, certain work-related injuries must be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, including those where the result is that the employee is unable to work for more than 7 days subsequently.[8]

Morbidity and mortality

An effective morbidity and mortality (M&M) meeting should identify events that have resulted in adverse outcomes, foster discussion, and lead to the dissemination of learning. Ideally this should be multidisciplinary and within a 'safe', non-critical environment where staff are encouraged to share and 'speak up', and focus on systems and process

Alan Macfarlane BSc (Hons) MRCP FRCA EDRA *is a consultant anaesthetist at Glasgow Royal Infirmary where he is clinical governance lead for anaesthetics and theatres. He is also an Honorary Clinical Associate Professor at the University of Glasgow. His major clinical and research interests are regional anaesthesia; he is treasurer of Regional Anaesthesia-UK, a member of the ESA scientific subcommittee for regional anaesthesia and an editor of BJA Education.*

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variations rather than individuals and blame. Cases that may be discussed include any deaths arising from elective surgery; deaths involving an unscheduled period in intensive care; deaths where it was necessary for the patient to return to the operating theatre within 14 days of initial surgery; deaths where a significant incident has been identified; or patients who suffered major complications but did not die. The Scottish Audit of Surgical Mortality was a nationwide process involving an external review of all perioperative deaths in Scotland. This no longer exists, but the structured judgement review is a national process introduced by the Royal College of Physicians using validated methodology to learn from mortality.[9] SALG summaries of anaesthesia-related incidents should also be reviewed at M&M meetings.

Risk register

This is a systematic record of risks to the organisation, with a description and severity rating of the risk, along with the impact and consequences. Many risks cannot be eliminated and therefore it must be decided whether to accept, manage, or possibly avoid (i.e. cease a certain procedure) the risk. The risk register should be reviewed regularly.

Effective care

Effective care for patients should be based on good quality evidence from research, and incorporates the use of guidelines, standards, and quality improvement (QI) processes. Guidelines and standards do not replace the need for experienced clinical judgement exercised by individual anaesthetists in the best interests of their patients, but they are very much intended to support this.

Guidelines

Where there is variation in practice that affects patient outcomes, and research demonstrates evidence of effective practice, guidelines such as those published by the RCoA, the Association of Anaesthetists, the National Institute for Health and Care Excellence, or the Scottish Intercollegiate Guidelines Network may assist practitioners in making decisions. Appropriately implemented, guidelines may potentially improve the quality of care for patients and increase the efficiency of healthcare organisations through standardisation.[10,11] However, although guidelines are usually developed systematically and with rigour, they can be open to interpretation. Hence they should still be scrutinised, and decisions made on how best to adopt them locally.

Standards

A standard is a statement, reached through consensus, which clearly identifies the desired outcome. Standards should be measurable, often through the use of audit, and also achievable. By meeting standards such as the voluntary ACSA standards, the quality of service provision should improve.

Quality improvement

The purpose of QI is to bring about measurable improvements by applying systematic change methods and strategies within a healthcare setting. QI has recently been described in more detail in this journal.[12]

Person-centred care

Patients, along with their relatives where appropriate, should be equal partners in planning, developing, and assessing care to ensure that it is the most appropriate for their needs. A safe experience may not be a person-centred one and a good experience might not be a safe one. Person-centred care also includes complaints and a process whereby these are reviewed and responded to in a timely fashion. Surveys of patients can form an important part of person-centred care, although these can be more difficult in the field of anaesthesia, where many other factors influence the experience of a patient undergoing surgery.

Assured care

Assured care is the process of ensuring that safe, effective, person-centred care occurs. Care may be assured either through voluntary (e.g. the ACSA standards) or involuntary (e.g. the Care Quality Commission in England, Healthcare Inspectorate Wales, and Healthcare Improvement in Scotland) mechanisms. Such inspections may be planned or unannounced. Failure to meet standards can, rarely, lead to suspension of services. The process of regular clinical governance meetings, and the dissemination of work and any changes undertaken is also part of the assured care process.

Declaration of interest

The author declares that they have no conflict of interest.

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