

Quality in healthcare – Part 5

Clinical Governance

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Over the past months we addressed different components which contribute in providing a good quality service. Clinical Governance (CG) encompasses all those elements and hence fittingly, this is the last in this series.

This term came into being in the 1998 DoH (Dept of Health in the UK) publication.

A First Class Service. Although the official definition is a mouthful, it is worth studying:

'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 underlining)

So, it was all about quality, quality improvement and excellence.

In order to achieve all these, we need certain tools - the sort we have been examining in the previous issues (and many more). Thus, CG has been compared to a huge tree from which various branches (its components) emerge. It is a living tree, and new branches keep sprouting all the time (while some old ones wither away).

Hence the following list is neither exhaustive nor static:

Components of CG:

1. **Best practice guidelines:** Given that advances in medical practice move so fast, the average clinician

needs to be advised what is best by 'the learned bodies' (RCOG, NICE). In order to develop the guidelines, one has to establish **clinical effectiveness based on evidence ('evidence-based medicine')**.

2. **Audit:** There is no point in 'knowing the right thing', if we are not 'doing the right thing'.
3. **Research and development:** Help to develop new ideas, and to enthuse the innovators.
4. **Education and training:** New recruits need to be trained.
5. **CPD:** Older ones need to keep on learning and refresh knowledge.
6. **Revalidation:** Somebody needs to check that this is happening.
7. **Complaint procedures:** Patient is our customer. If 'customer is king', perhaps we should listen (and act) when he or she is not happy.
8. **Clinical risk management:** There can be no meaningful quality in a service if it is too 'risky'. Eliminating and minimising such risk is an essential part of a 'first class service'.
9. **Service accreditation:** This applies to Units as well as individual practitioners. Colposcopy accreditation is a good example.

Drivers

Most of the above would not happen if just left to the goodwill of the

providers. Some form of compulsion is necessary. Therefore, in the above definition the most important word is 'accountable'.

This document made the CEO of the Trust *personally* accountable for the quality of healthcare his organisation provides. This got the ball rolling very quickly and the Trusts put in place all those components listed above.

E.g. In the past if you cut a ureter it remained your own clinical responsibility. Still is. However, if you *keep on* cutting them, it also becomes a *corporate* responsibility. How did the system allow this to happen? What steps is it going to take to prevent it in future?

Another powerful (external) driver is the fear of litigation; this has been addressed elsewhere, under risk management.

Conclusion

Unfortunately, Sri Lanka has far to go to establish such systems. But even in the UK, all these processes are fairly recent and developed gradually over time. We too have to start somewhere. I would suggest we start in the teaching hospitals, making them 'centres of excellence' from whom others could learn.

However, as we have seen in the UK some kind of compulsion might be required to get things moving.

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Competing interests: None