CLINICAL GOVERNANCE

An overview
Who is responsible?

- Policy on re-engineering developed in June 2011
- Advertisement of District Clinical Specialist (DCST) posts in October 2011
- Recruitment (national) done in February – May 2012
- DCSTs functioning started July 2012
- Provincial recruitment to complete teams continuing to-date
- At the national induction workshop in September 2102 only 9 of the 52 districts had complete teams
- The more rural districts struggle to attract specialist. Only 1 of the 4 districts in North West Province currently has a complete team
- Five phase induction process started in September 2012
Five phase induction process

- Phase 1: Induction, Orientation and working in teams
- Phase 2: Situational analysis of district health services
- Phase 3: Data management and reporting
- Phase 4: Quality improvement/clinical governance
- Phase 5: Leadership and system management
CLINICAL GOVERNANCE

“framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.” (Scally, G., Donaldson, L.J. British Medical Journal 1998; 317: 61-65)
Alternatively....(2)

• Clinical Governance “encapsulates an organisation’s statutory responsibility for the delivery of safe, high quality patient care and it is the vehicle through which that accountable performance is made explicit and visible.” (Halligan, Prof. A. Clinical Governance: assuring the sacred duty of trust to patients. Clinical Governance Support Team: 2005)
Alternatively... (3)

- Clinical governance is an initiative to ensure health facilities have in place a system to support continuous improvement in the quality of care. This includes having policies and procedures to safeguard patient care and, importantly, promoting an organisational culture that encourages patients, visitors and staff to report any concerns they may have or make suggestions for improvement. In addition, the clinical governance system should include, (i) fully functional procedures for professional development, (ii) appraisals, (iii) effective team management and, (iv) adverse incident reporting system(s).

Seven pillars of clinical governance

1. Service user, carer and public involvement
2. Clinical effectiveness
3. Clinical risk management
4. Education, training and development
5. Use of information
6. Staffing and staff management
7. Clinical audit
Service user, carer and public involvement

- Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.
Service user, carer and public involvement (2)

• Patients receive services as promptly as possible, have choices in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway.
1. Service user, carer and public involvement?

- How are service users and their carers involved in the Clinical Governance agenda?
- Are carers involved in the care and treatment of the person they care for?
- What processes are there for service users and carers to make their views known?
- How do they get feedback?
- Is there learning from complaints?
- Are privacy, dignity and confidentiality issues addressed?
2. Clinical effectiveness

- Patients achieve health care benefits that meet their individual needs through health care decisions and service based on what assessed research evidence has shown provides effective clinical outcomes.

- Clinical effectiveness means the degree to which the organisation is ensuring that ‘best practice’, based on evidence of effectiveness where such evidence exists, is used.
<table>
<thead>
<tr>
<th>PRIORITY 1</th>
<th>New patients (adults, adolescents and pregnant women) eligible to start ART</th>
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| PRIORITY 2 | 1. All pregnant women needing triple therapy  
2. Breast feeding mothers currently stable on a FDC compatible regimen. |
| PRIORITY 3 | Virally suppressed patients currently on first line regimen, requiring a switch due to toxicity (e.g. stavudine) |
| PRIORITY 4 | Patients currently stable on a FDC compatible regimen, with TB comorbidity |
| PRIORITY 5 | Patients currently stable on a FDC compatible regimen with other comorbidities (e.g. hypertension, diabetes mellitus, etc.) |
| PRIORITY 6 | Patients currently stable on TDF-based regimen and who request a switch to a FDC |
| PRIORITY 7 | Patients currently stable on TDF-based regimen who, after counseling, agree to a switch to a FDC |
2. Clinical Effectiveness?

• Clinical effectiveness means the degree to which the organisation is ensuring that ‘best practice’, based on evidence of effectiveness where such evidence exists, is used.

• Are changes in practice brought about by use of evidence-based methods?

• Are staff aware of how to access appropriate knowledge management resources?

• Is there a wide understanding throughout the organisations of the guidelines?
3. Clinical Risk Management

• Patient Safety is enhanced by the use of health care processes, working practices and systematic activities that prevent or reduce the risk of harm to patients.

• Office of Health Standards Compliance

• National Core Standards, Patient Complaints, Adverse Events
National Core Standards

- 7 domains:
  - Patient rights
  - Patient safety, clinical governance and care
  - Clinical support services
  - Public Health
  - Leadership and corporate governance
  - Operational management
  - Facilities and Infrastructure

- 6 priority areas:
  - Values and attitudes of staff
  - Cleanliness
  - Waiting times
  - Patient safety and security
  - Infection prevention and control
  - Availability of basic medicines and supplies
National Core Standards

- **Domain**
- **Sub Domain**
- **Standard**
- **Criteria**
- **Measures**

- **Vital measures** are those that ensure that the safety of patients and staff are safeguarded so as not to result in unnecessary harm or death.

- **Essential measures** are those considered fundamental to the provision of safe, decent, quality care and are designed to provide an in-depth view of what is expected within available resources.

- **Developmental measures** are those elements of quality of care to which health management should aspire to, in order to achieve optimal care.
Medical Negligence (2011)

- In April 2011, 4 cases of medical negligence have been settled in Johannesburg, with payouts of up to R7-million.

- MPS members are facing more than 800 active claims of alleged negligence, with another 1000 complaints still to be assessed.

- Botched cosmetic surgery, children born with brain damage, birth defects not diagnosed timeously and Caesarean sections not done when needed.

- About 80% of the claims stem from incidents in the public health sector, and as many as 70% of all claims are settled out of court.

- Over 18% of claims are worth more than R1-million, (up 550% compared with 10 years ago), the number of claims for over R5-million has increased by 900% in the past decade.

- Statistics from the Health Professions Council of South Africa show that 44 doctors have been struck from the roll since 2005 due to unethical and unprofessional conduct.

- Between April 2008 and March 2011, about 90 doctors were found guilty of medical malpractice, including cases of insufficient care, refusing to treat patients, misdiagnosis, practising outside of scope of competence, overcharging or charging for services not rendered.
3. Clinical Risk Management?

- Is there an open and reasonable-blame culture?
- How are incidents and near misses reported?
- Do we liaise with other organisations where care is shared?
- What preventative measures are in place?
- What improvements to patient care have resulted from clinical risk management?
Current system for handling complaints

Complaint

- Services rendered by public hospitals
  - Public Health Facility
    - If not satisfied with the outcome
      - To SAE/Litigation
        - National
          - Future ombud (*)

- Professional conduct/medical schemes
  - Statutory/professional bodies
    - To litigation

- Services rendered by private hospitals
  - HASA/Main private hospitals groups
    - * Complainant can contact ombud directly (preferably after he/she has gone through the above process)
Complaints logged at Facilities for the 2011/2012

### Average resolution rate:
83%
National Core Standards Audit Results on Complaints Management: Standards (OHSC)

85 PHC Facilities Audited from February to November 2012

1.8.1 Pt complaints are managed systematically and to pt satisfaction

1.8.2 Complaints are used to improve service delivery
4. Education, Training and Development

- Health care organisations work together and with social care organisations to meet the changing health needs of their population by:
  a) having an appropriately constituted workforce with appropriate skill mix across the community; and b) ensuring the continuous improvement of services through better ways of working
- Skillsmart NDoH
4. Education, Training and Development?

- What opportunities are there for training or formal education?
- Do all our staff receive a yearly appraisal?
- Are relevant staff undergoing the mandatory training?
- Are changes made following external assessments?
5. Use of Information

• Health care organisations use effective and integrated information technology and information systems which support and enhance the quality and safety of patient care, choice and service planning.

• Advocacy should target the same indicators as DoH. “Talk the same language”

• Patient Cascade/ Process
Patient process – PMTCT

**Pregnancy education**
- ? PHC re-engineering indicators

**ANC**
- Antenatal visits before 20 weeks rate
- Antenatal coverage (annualised)
- Antenatal client HIV 1st test rate
- Antenatal client HIV 1st test positive rate
- Antenatal client HIV re-test positive at 32 weeks rate
- Antenatal client CD4 1st test rate
- Antenatal client initiated on AZT during antenatal care rate
- Antenatal client initiated on HAART rate

**PNC**
- Postnatal Care mother visits within 6 days rate
- Postnatal Care baby visits within 6 days rate
- Baby Nevirapine uptake rate

**Child Health**
- Baby PCR test around 6 weeks uptake rate
- Baby PCR test positive around 6 weeks rate
- Baby Co-Trimoxazole around 6 weeks uptake rate
- Baby HIV antibody test around 18 months uptake rate
- Baby HIV antibody test around 18 months positive rate
- Baby initiated on HAART under 18 months rate
- Infant Mortality rate
5. Use of information?

- Have clinical staff been involved in specification of information requirements? (NIDS)
- Are there multi-disciplinary health records, residing in a single file?
- What training is there for staff in accessing and using information?
- Does information used by teams include ‘the patients’ experience?
6. Staffing and Staff Management

- Health care organisations work to enhance patient care by adopting best practice in human resources management and continuously improving staff satisfaction.
- Proper “Workforce planning” practices aimed at optimal attraction, recruitment and retention of health professionals.
- Linked to Education, training and development pillar of clinical governance.
6. Staffing and Staff Management?

• Are staff aware of their responsibilities under Clinical Governance?
• How is staff absence and use of temporary staff monitored?
• How is poor performance identified, monitored and managed?
• Is there team working within teams and between teams?
• What support systems are there for staff?
7. Clinical Audit

• Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services
• Clinicians are involved in prioritising, conducting, reporting and acting on clinical audits.
• Clinicians participate in reviewing the effectiveness of clinical services through evaluation, audit or research.
7. Clinical Audit?

• What improvements to the service user experience result in practice following audit?
• How do the audits link to the national and local agenda?
  National Core Standards
  Benchmark indicators
• How are audit results communicated?
• How are service users and carers involved in audits?
Clinical Audit and Quality Improvement

• Structure, Process and Outcome indicators
• Indicators have associated criteria (“questions with yes/no answers that define the indicator) and a standard to be reached (target)
• Include examples
Clinical Governance Committees

- Clinical Audit Steering Group
- Clinical Risk Management Group
- Infection Control Committee
- Medicines Management Committee
- Guideline Implementation Committee
- Research and Development Committee
- Therapeutics Group
- Training and Development Committee
Key Indicators of Success - Internal

- Users and carers believe that they are well cared for. *(Patient Survey, Complaints)*
- All members of staff feel included, listened to and empowered. *(Staff Survey)*
- All members of clinical staff regularly undergo clinical supervision.
- The governance committees have safety and quality high on their agenda every meeting.
- There is an increase in the reporting of incidents and near misses.
- As we start sharing learning from incidents, we will see a decrease in the number of incidents occurring.
- Internal benchmarking of clinical data indicates change in clinical practice, particularly in relation to guidelines
- Recruitment and retention rates improve.
Key Indicators of Success - External

- Continued compliance with the Office of Standards Compliance
  - adverse events
  - patient complaints
  - norms and standards
- Increasing patient and staff survey satisfaction, monitored using national surveys.
- 100% of staff report that they have an annual appraisal.
- Successful clinical governance related assessments by the external auditors.
- Successful Mental Health Act Commission assessments.
Roles and Responsibilities – Individual

- Undergoing a minimum of an annual cycle of self-reflection about their practice as part of a Performance Appraisal Process.
- Developing individual objectives as part of a Personal Development Plan including practice competence issues.
- Reflecting on the service user and carer experience.
- Ensuring they are committed to maintaining a high quality service to patients by continual development of practice.
- Ensuring professional accountability and self-regulation.
- Committing to continuing professional development and creating a learning environment.
Roles and Responsibilities – Senior Management

• Supporting individuals.
• Ensuring accountability arrangements and systems are in place within their services.
• Ensuring all staff attend training.
• Promoting a culture that supports learning and encourages reporting; having systems in place to deal with and learn from incidents and complaints, and to identify and manage risks.
Roles and Responsibilities – Head of Clinical Governance

• Support the Local Clinical Governance Groups in developing their action plans.
• Support the Local Clinical Governance Groups in producing an annual report on activity and progress.
• Prepare reports on the progress against the strategy for the Clinical Governance Committee.
• Produce a Clinical Governance Annual Report for the Trust Board and Strategic Health Authority.
• Support the dissemination of good practice.
• Provide strategic leadership.
• Provide advice and guidance.
Complexities of Clinical Governance

Challenges of Coordination

1. Self-referral (direct access)
2. Administrative (indirect referral)
3-5. Referral for consultation/management
   3. for diagnostic assistance (advice on diagnostic assessment)
   4. for assistance with therapy (advice on therapeutic intervention)
   5. for ongoing management
6-9. Return to primary care
   6. for better specification of problem
   7. for diagnostic work-up
   8. for therapy
   9. for ongoing management
10. Cross-referral
11. Primary care involvement in decisions about cross referral


Starfield 1997
A story be told at a random hospital:

With regards to his neglect to advocate on behalf of his patient:

- Dr L. did NOT suggest to his colleague that Mr. Biko should NOT be left lying on the floor... because there were no beds available
- He did not keep his patient under medical surveillance... because of staff shortages
- Nor did he keep (his medical colleagues) completely informed....about his medical condition... because of poor channels of communication between facilities.
- He believed that Mr. Biko could not be transferred to a prison hospital because there was a risk with transport.
- Dr L. did not examine the vehicle to ensure that conditions to transport a seriously ill patient were acceptable... because he was too busy
- Nor did he insist that Mr. Biko be escorted by medical personnel... knowing that BAAs are not available
- Nor that his medical records should accompany him during the transfer... because the admin and IT systems are not capacitated for t/f of that information