

2004 Chief Health Officer Seminar Series

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Abstract:

Clinical Governance

The governance arrangements that underpin ACT Health continue to evolve. One area that has undergone major revision over the last two years is the clinical governance arrangements. This paper considers the concept of governance as it applies in a clinical setting and traces the notion of clinical governance from its beginnings in the UK and Australia. It considers the meaning of the term in Australia and its application by ACT Health.

The paper focuses on the core dimensions of a clinical governance framework: clinical competence, clinical risk management, and clinical effectiveness. It concludes with a consideration of the supporting structures and accountability arrangements that are required to sustain the system.

Transcript:

It's an unfortunate fact of life that it usually takes a major disaster for people to realise they have failures in their system.

In health care in Australia it was only in the middle nineties that we started to suspect there were problems with our system. We suspected, but we really didn't know. We suspected because other systems in other countries were identifying major failings and some major hospital failures, notably the disaster at Bristol in the UK in the middle nineties, started to flag to us that we had some problems.

The seminal study in Australia was undertaken in the middle to late nineties and it identified something frightening, in particular to our Health Ministers.

That study identified that about 10 per cent of all hospital admissions were associated with an adverse event. Of those events, two were significant, so significant that out of 100 patients admitted to hospital 0.3 per cent would die, not because of their illness, but because of the circumstances in which they received care.

If you put that into perspective there's about 50 people in this room; if we were all admitted to hospital then three or four of us would have an adverse event. Should we worry about that?

If we fly we don't expect a plane to crash. We accept that flying in an aircraft is safe - yet at the time of the seminal health study we could see that there were system failures that were causing significant adverse events to occur. The Australian Government decided this was unacceptable and initially established a national expert advisory group to determine what we should do about it.

Out of that came the establishment of the National Safety and Quality Council. That council, established in 1999, has since been undertaking the major body of work in Australia around improving our health care system from a safety and quality perspective. One of the key topics on their agenda today is the topic of clinical governance.

Within the ACT, ACT Health has been working towards the improvement of its quality and safety systems. Several years ago a document dedicating the ACT to quality and safety was produced and the ACT is about to publish its health improvement plan.

You should note that this health improvement plan includes for the first time a section on clinical governance.

So what is clinical governance? First of all we need to think about what is governance. I am going to take you through a short journey from governance to corporate governance and then finally to clinical governance.

First, some significant definitions on governance. If you look at the words they actually talk about things like direction, control and management of outcomes.

In the corporate world corporate governance has become important again because of systems failures. You will recall over the last twenty years a number of major corporations have failed. As a consequence much work has gone into identifying why those systems failed and the governance arrangements that underpin them. The notion of corporate governance flowed on and now is well and truly imbedded in the commercial world. The Australian Stock Exchange definition of corporate governance draws on the same sort of notions as the previous definitions of governance.

The ASX definition is: "Corporate governance is the system by which companies are directed and managed. It influences how the objectives of the company are set and achieved, how risk is monitored and assessed, and how performance is optimised. Good corporate governance structures encourage companies to create value (through entrepreneurship, innovation, development and exploration) and provide accountability and control systems commensurate with the risks involved."

It's around direction, it's around management, it's around performance, but you'll note for the first time that we have a definition that's identifying risk and how we monitor and manage risk.

The term 'clinical governance' was first coined in the UK. It was a consequence again of the outcomes of the Bristol enquiry that had profound effects on the UK health system, so much so that the NHS has restructured almost totally to resolve what the authorities termed 'the clinical governance problems'. They embarked on a process of renewal to overcome them.

The NHS defined clinical governance as: "A 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."

They had a very broad definition of clinical governance. It really doesn't sit within the rubric of those previous definitions. It's more about continuous improvement, the right sort of catchwords around safeguarding high standards, ensuring that we are creating an environment that flourishes clinical excellence.

So it's a very soft and wordy definition of governance when you compare it to the hard nosed corporate definitions. In Australia we've sat somewhere between the two sets of definitions.

The way it's usually viewed in Australia is that it's an audit of a collective arrangement of concepts and activities that relate to safety and quality in performance, accountability and responsibility in the delivery of health care.

So what we are saying in Australia is that clinical governance links safety and quality into the way health care is delivered in an organisation and in accountability to the hierarchy that underpins it. So probably another way of looking at it is to say it's a framework that outlines and addresses the lines of accountability and responsibility that link consumers and patients, through clinicians, clinician managers and executive ultimately to government.

At the same time in Australia we would argue that it's also about recognising and resolving problems that might arise along the patient's journey. It's about doing that without apportioning blame, while noting that ultimately if mistakes are made and they are of a nature that includes individual error, that at some stage the regulatory framework might come into play.

We look at clinical governance under four headings: the competence of our clinicians to do their job; risk management (so linking that notion of risk with governance); clinical effectiveness (that's improving the quality of our care); and finally how do we manage and enhance our system. I'll deal with each of those four in turn.

Clinical competence is about our people. Why does it sit there as one of the core dimensions of a governance framework? Anybody who looks at the factors that are associated with systems failures will recognise that in almost all circumstances - and some could argue radically in all circumstances - there is a human factor associated with them.

At the end of the day you can draw a link between each factor back into the human being, a person, and it is the competence of that person to do their job that is ultimately the driver of safety and quality. So clinical competence has to be one of our core dimensions.

What does it actually refer to? Well, it refers to the knowledge, skills and attributes of an individual to do their job. From a systems point of view we must have a standard against which we can assess and judge people, a code of conduct, a code of behaviour, a code of ethics.

It is interesting to note in the health sector that there is no overarching defining code of behaviour. There are a variety of codes. The medical profession has a series of codes within that professional group. The AMA has a code of practice. Some of the professional colleges have codes of practice. Medical students have codes of behaviour, but there is no single entity that links all of those codes. They have similar values, sometimes complementary. None that I have looked at are in conflict, but it is interesting that there is no overarching code.

To underpin a system of clinical competence to ensure our people are competent, it's now well and truly accepted that the key driver is not just the people as they are, but the maintenance of competence - the professional development and training that they require to maintain their competence as they journey through their careers.

On a day to day basis though, and very much from a practical point of view, clinical competence has to be managed and part of that management should be through an organisation's performance appraisal system.

I think it's ironic that in the health sector, and especially amongst our clinicians and particularly the medical professions, there is substantial resistance to involvement in performance appraisal and performance management. It's really only been in Australia in the last three or four years that health care systems have started to impose a performance appraisal system.

As I look at those frameworks I see they are very rudimentary in comparison to most other sectors. At best they allow a supervisor to provide some form of advice and feedback on the performance of an individual. But they tend not to touch on skills and knowledge, usually focusing on personal attributes.

In Australia today our performance appraisal systems, especially for our medical professionals, don't involve the other elements of 360 degree reporting. There is very little feedback to supervisors on the support that they receive to provide their service.

And again it's ironic that medical professionals claim they undertake peer review, but they tend to peer review a small attribute and that attribute is usually around adverse events, adverse outcomes as against skills and knowledge. So an area where we could use our peer review to inform each other as professionals isn't being used, especially in the medical profession.

Other areas of competence that are important to address and ensure are being addressed concern the supervision of junior staff and appropriate supervision of staff. Out of all that there is a requirement for a governance arrangement that ensures competence is attained and maintained and you will see as I deal with each of these areas that there's actually a parallel system of governance that's in place.

There are the line management lines of accountability and responsibility. In health care though we support that with a second and parallel system of committee structures that support line management in the fulfillment of their activities and around competence. The usual way that's addressed is through what's known colloquially as clinical privileges committees.

These committees are peer-based committees that have the responsibility of confirming scope of practice at the time of appointment, to conduct routine review of performance and, in exceptional circumstances, to review the performance of an individual where it's felt that individual is poorly performing. I would argue though that it's very difficult for a clinical privileges committee to function without a sound and robust system of performance appraisal.

The second area that I'll deal with, as part of the rubric of clinical governance is around clinical risk management. I hinted at the fact that risk management is pivotal when I identified that, in the corporate world, it is identified as a key issue. How important is it to us in the clinical world? I argue it's critical. Adverse events do occur. They occur all the time and some lead to death or disability. If you risk assess a health care organisation and use standard risk assessment tools, you'll find the majority of extreme risks that confront a health organisation are those risks associated with patient care. Extreme corporate risks are in the minority.

So clinical risk management has to stand they're as one of the key pillars of clinical governance. Clinical risk management recognises that errors can occur anywhere in the journey of care of a patient, starting in the community, through the acute care sector and into rehabilitation and eventually in their return to the community. So we're not just focusing on one element of a system, we've got to focus on the whole system.

It's about risk identification from a clinical perspective and about how we go about identifying risk, how we go about identifying adverse events and managing them.

The other day I was talking to somebody about risk analysis in the health sector and they said 'well surely you've got a common system to identify adverse events and analyse them, it should be pretty easy to do that'. Unfortunately I had to reply 'no, there's not because we've got a whole series of ways of identifying adverse events, but none of those systems are common or are the same'.

For example, we have a system of incident reporting in our hospitals in the community health, mental health services, but it's a voluntary reporting system. There's a failure in that particular system because not all staff use it. It was introduced and it's been championed by nursing professionals who use it quite regularly, but medical professionals would rarely use it in incident monitoring. Some do, but the majority don't.

There are some forms of obligatory reporting, but they are only used in the most extreme events, the sentinel events, and it's only in April this year that Health Ministers decided to make it compulsory to report what's known as a sentinel event. Sentinel events occur very rarely, and they are clearly defined, but as I say they occur rarely, so it's only those few extreme events that there's even any form of mandatory reporting against.

Having said that there are other sources of information that identify adverse events. Our consumers routinely identify what's going wrong and report by way of complaints. But again, many of our health care organisations deal with complaints just as complaints, rather than as patient/consumer identified adverse events.

Our staff identify adverse events and we call it incident monitoring. Our patients identify adverse events, but we call it complaints. There's a mismatch there in what we're doing and how we're identifying adverse events. There are other regulatory and legal bodies that do identify adverse events – the health complaints commissioner analyses adverse events, again complaint generated, and the coroners do as well, but at this stage we don't have a systemic and integrated approach of analysing those adverse events.

We do have tools available to us that allow us to analyse those events. We can aggregate data and review it, we can conduct record review, we can conduct ad hoc audits, and we can conduct what's known as root cause analysis that bores in great detail into an adverse event. So the tools are available, but it's a matter of knowing which one to apply and when.

At the end of the day what we should get out of risk management is a risk reduction plan. From that plan we should identify all layers that need to be addressed. It's not just around clinical practice, it has to start with policy, the procedures and then practices.

At each layer there are different levels of responsibility and accountability. If you think about them, senior management are usually involved in policy and advice on legislation and clinician managers are interested in procedures and clinicians on day to day practice. And while it's last but it's not least, our consumers must have responsibility for the safety of the care that's delivered to them by way of feedback and advice on their thoughts on the care and the quality of that care.

Having spoken about the internal systems, there are other systems that should allow us to determine the quality and safety of the care that we provide. Benchmarking is one such activity, but in Australia today benchmarking activities are of a voluntary nature.

There are a number of accrediting and certifying bodies that will look at the safety and quality of health care that's provided to us. But it should be noted that while these benchmarking exercises and activities are ongoing, questions have to be raised about the success and or failure of such an activity.

I think it's well known that a number of the failed hospitals in Australia today had all been through an accreditation process and had been through it successfully with minor comments on systems failures. So even the system of benchmarking is demonstrating failures today. The third area of governance is actually around clinical effectiveness.

Thus far I've looked at what goes wrong, the safety side, so let's minimise harm. You can't do that though without saying 'right oh, at the same time we've got to improve the quality of our services'. The quality side of it is achieved through systems of effectiveness which are about establishing and maintaining processes that ensure that we use appropriate clinical pathways and guidelines, practice statements and the like. But even these must be underpinned by agreed levels of care and standards of care.

There are processes that allow us to do this – role delineation, definitions of access and the like - but it needs to be remembered that all of these are at best ad hoc systems and at worst are failed systems. Within these again you can see there are lines of accountability and responsibility that have different responsibilities depending on where they are within the system.

It is around a hierarchy of accountability that holds government ultimately responsible for the care that we receive. Governments achieve that through legislation and regulation. Health departments' responsibility is at the policy level, area health services networks, policy and sometimes procedures. Hospitals' responsibilities are usually around the procedural level and some policies and clinical units around day-to-day procedures and practices.

You can see that governance has a different meaning to people depending on where they sit in the health care system. I haven't included the consumer in this discourse however at the end of the day we must appreciate that ultimately this system is around providing care to a consumer and that consumers also have responsibility for the quality and safety of care that they receive.

So having said all that there's only one concluding thought.

We all do know that providing health care and receiving health care is a risky business. The risk isn't just to the patient, it's also to the practitioner and ultimately to the organisation. What we seek to achieve through a sound and robust clinical governance framework is a set of arrangements that will minimize harm to patients and at the same time allow us to continue to improve the quality of care they receive.