An overview of clinical governance policies, practices and initiatives

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Abstract

Objective: To map the emergence of, and define, clinical governance; to discuss current best practices, and to explore the implications of these for boards of directors and executives wishing to promote a clinical governance approach in their health services.

Methods: Review and analysis of the published and grey literature on clinical governance from 1966 to 2006. Medline and CINAHL databases, key journals and websites were systematically searched.

Results: Central issues were identified in the literature as key to effective clinical governance. These include: ensuring that links are made between health services' clinical and corporate governance; the use of clinical governance to promote quality and safety through a focus on quality assurance and continuous improvement; the creation of clinical governance structures to improve safety and quality and manage risk and performance; the development of strategies to ensure the effective exchange of data, knowledge and expertise; and the sponsoring of a patient-centred approach to service delivery.

Conclusions: A comprehensive approach to clinical governance necessarily includes the active participation of boards and executives in sponsoring and promoting clinical governance as a quality and safety strategy. Although this is still a relatively recent development, the signs are promising.

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What is known about the topic?

Clinical governance is a relatively new and increasingly accepted approach to the improvement of quality and safety in health services.

What does this paper add?

This paper examines clinical governance policies and practices as enacted in Australia and internationally. Few previous papers have taken such a wide-ranging approach. The paper considers a number of strategies in detail, and reflects on their implications for health services boards, executives and practitioners. It provides links to major journals, reports and jurisdictions. It concludes that a robust approach to clinical governance involves the participation of all major stakeholders.

What are the implications for practitioners?

While a range of approaches is possible, the active participation of executives and boards is essential if the stated goals of clinical governance are to be achieved.

WHILE CLINICAL GOVERNANCE is a relatively recent idea, there are nevertheless more than 1000 articles, several books and a range of chapters and monographs dealing with the topic. In order to be comprehensive, we conducted a thorough review of the clinical governance literature from 1966 to 2006 using the Medline and Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases and available grey literature. We provide both a description and an analysis of clinical governance in the context of Australian and international health care. A broader analysis of the literature is available elsewhere.[1] Our aims in this paper are normative. We seek to stipulate what clinical governance is, to discuss what the best clinical governance practices are and canvass the role of boards of directors and executives (ie, the collective groups with responsibility for organisational performance) in sponsoring a clinical governance approach in their health sector organisations.

The emergence of clinical governance

Clinical governance as a term was first introduced in the 1990s in the National Health Service (NHS) in the United Kingdom.[2] It has become popular as a response to a series of concerns about the quality and safety of health care in the United Kingdom,[3] Canada[4] and elsewhere.[5] There had been several highly publicised breaches of patient safety, the most notable of which was dealt with extensively by the Bristol Inquiry.[6] The context at the time was that demand on services had been increasing, there was a rise in patients' willingness and ability to stipulate what they required from the health system, costs were escalating and the actual or threatened use of litigation when things went wrong were collectively perceived to or led to increased pressure on health systems to get things right.[7] Hence, the idea of involving clinicians in reforms, including governance processes, took root.

These conditions of rising demand, increasing consumer participation, cost pressures and litigiousness prevailed in Australia in the 1990s and 2000s too. There have been large-scale patient safety inquiries in Western Australia (the Douglas Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital 1990–2000);[8] New South Wales (Special Commission of Inquiry into Camden and Campbelltown Hospitals);[9] and Queensland, at Bundaberg (Queensland Public Hospitals Commission of Inquiry).[10]

Added to this high-profile flurry of judicial inquiries, research studies have shown that error rates, near misses and adverse events are at persistently high levels, and appear to exhibit considerable resistance to policy or managerial efforts to reduce them.[11-14] All of this suggests that quality and safety have to be taken very seriously indeed and the problems cannot be ignored. Clinical governance in many respects is a response to this set of circumstances. Nevertheless, the evidence points to the fact that there are no magic-wand solutions to quality and safety concerns. To change health systems for the better requires multiple strategies and will likely be a longitudinal task, taking perhaps a generation, with considerable focused effort required from numerous stakeholders. This should not be a surprise; systems change rarely happens swiftly,[15] perhaps only when there is a grave crisis promoting immediate, thoroughgoing transformation. Patients die or are injured one at a time, and this has not precipitated a crisis in the health system. Imagine if a similar number of people died in the aviation industry, say if a jumbo jet full of passengers crashed each week.[16] There would be an outcry, and immediate rectification action taken. A similar shift to immediate action is not happening in health care.

What is clinical governance and how has it been endorsed by governments?

One of the early definitions of clinical governance came from Scally and Donaldson: "a system 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."[2] (p. 62) What is meant by a clinical governance framework is a set of initiatives designed to enhance care, and the promotion of a productive culture and climate within which care can thrive. The Office of Safety and Quality in Health Care in Western Australia, in part as a response to the King Edward Memorial Hospital inquiry in that state, wrote a monograph entitled *Introduction to clinical governance — a background paper*, released in 2001.[17] The Western Australian government agreed in this report on this definition of clinical governance: "a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes". (p. 2) With this added definition, we can discern that longer term outcomes are the end result, and the clinical governance framework is to be operationalised in a methodical, coordinated manner.

Early literature advocated strategies in favour of clinical governance as a new way of emphasising clinical, professional and organisational improve-

ments.[2,18-23] Some critics demurred, suggesting this was a fad, a "new label for old ingredients", more top-down managerialism, that clinical governance was more conceptual than useful, or that it would require more of a culture change to implement than had been suggested by its proponents.[24-28] Supportive literature outweighs criticisms by a considerable margin. There are now several useful books covering the topic.[29-33]

The role of the relevant government agency responsible for health is to specify to providers what is to be achieved in exchange for the funding they allocate, with expectations that the role of the provider of services is to assure and safeguard high-quality services and safety for patients. This raises a number of complexities and quite significant difficulties. One central complexity is that health service provision involves the delivery of millions of services by thousands of health professionals to hundreds of thousands of ill patients using complicated equipment, procedures and processes. A major difficulty is that a zero error rate, such as is aspired to in the aviation or mining industries,[34-37] is not seriously possible to get close to, let alone achieve, in health care. People are living longer, with more serious illnesses and multiple comorbidities, and treatment is complex, sometimes risky, even dangerous. But experts agree that we can do much better in enhancing systems[38] such that error rates are mitigated, and health outcomes continuously improved.

Broadly, the jurisdictions in Australia have embraced clinical governance by attempting to hold health care providers accountable for the quality and safety of care they deliver. Information about websites, which document their approaches and provide considerable useful information, can be found below.

Links to corporate governance

Corporate governance is concerned with running organisations and businesses efficiently, and within legal constraints. While there are many definitions of corporate governance, there are several elements which iterate across various scholarly accounts: corporate governance is about the effective management of corporations, discharging fiscal responsibilities, creating acceptable returns on investment, the direction and control of boards and executives and the structures and decision-making processes to achieve corporate goals. Corporate governance should be centrally concerned with fairness, transparency and ethical business practices.[39]

Clinical governance is clearly closely related, because it too is concerned with accountability, effective end results, acceptable resource use and appropriate ways of working and behaving. One essential difference is that corporate governance is focused on the board room and the executive suite, and clinical governance is associated more closely with the ward, unit, department, health centre and clinic. In what follows we try to bridge that divide, and outline what clinical governance strategies are necessary, and what the role of boards and executives might be, in furthering a clinical governance approach.

Specific topics related to clinical governance

From the foregoing, it is clear that while it is a relatively new term, clinical governance is a crucial issue. It concerns quality care being delivered to the right patient on time, in a coordinated manner. In the last decade, policymakers, managers and clinicians have started to tease out what actually has to be done to promote good clinical governance. This includes: accountability, vigilant governing boards and bodies, a focus on ethics and regulating qualified privilege. It also includes taking steps to institute measures such as continuous improvement, quality assurance, audit, applying standards and ensuring they are met, using clinical indicators, encouraging clinical effectiveness, promoting evidence-based practice, participating in accreditation processes, managing risk, reporting and managing incidents, focusing on patient safety, improving the sharing of information, supporting open disclosure, managing knowledge effectively, obtaining patient consent, providing feedback on performance,

promoting continuous education, dealing with complaints effectively, encouraging consumers to participate in decisions affecting their care and credentialling medical practitioners.

We provide a section on these topics as a way of explaining the constituent elements of a clinical governance approach, and showing how clinical governance is realised through a range of strategies. Despite the long list, we have not intended to be exhaustive; there are other strategies that can be employed. However, these are some of the main initiatives envisaged under the rubric of clinical governance, and to a greater or lesser extent they have been implemented with some success in various settings. We have grouped them under four broad headings: *Advocating for positive attitudes and values about safety and quality; Planning and organising governance structures for safety and quality; Organising and using data and evidence;* and *Sponsoring a patient focus.*

Before presenting these, however, we should set the scene. One starting point is to say that governance of all types begins at the highest level, and it is a leadership issue to set organisational agendas for corporate and clinical governance. This means that boards and executive groups need to be highly vigilant. Having adequate reporting mechanisms and reviewing clinical and organisational performance through accurate data on a regular basis are preconditions to effective board and executive leadership. Board members and executives need to assure themselves that the organisation is performing effectively, that services are being delivered according to predefined standards and that mechanisms are in place to take remedial action when problems are encountered.

Advocating for positive attitudes and values about safety and quality

At the core of clinical governance strategies lies an overt commitment to the principles of quality and safety. The translation of these principles into practice depends on a combination of knowledge, skills and attitudes. In this section we examine the key values which board members, as well as clinicians and managers, need to encourage, support and display, in order to achieve high quality and high reliability services.

Accountability

At its heart accountability seeks to specify account-giving behaviour. It asks to whom is someone responsible and for what are they answerable? On the surface this seems to be easy to resolve, but because of the complexities of health care and the diffusion of responsibilities it is not. Clinical professionals, for example, are accountable to their patients for the standards of care they deliver. They also have responsibilities to their College and registration board. Executive groups and boards often want to hold clinicians and managers accountable for the exercise of financial performance, human resource management and professional conduct, but in times of shortage of staff, say, it is difficult to know how far to push accountability. For example, if clinicians are pressed too hard, they may leave or go into private practice. Ultimately, boards and chief executives are accountable for the standard of service delivered and do have to accept this obligation, despite difficulties in practice, in creating accountable organisations. Boards and executives also have to hold individual clinicians to account in performing their duties, often while simultaneously permitting levels of autonomy, not least because of the high levels of expertise many clinicians hold and exercise.

Continuous improvement

In older terminology, activities designed to apply standards to health care services were called "quality assurance". This term suggested that quality of care could be guaranteed, and as it cannot, due to the complexities and difficulties discussed earlier, that term fell out of favour. Now, people use the phrase "continuous improvement", by which is meant those clinical and organisational initiatives instituted to enhance quality and safety on an ongoing basis. Strategies under the continuous improvement banner involve long-term efforts to enhance services and health outcomes on a positively inclining gradi-

ent. Like the term "clinical governance", continuous improvement is an umbrella phrase, some of the main elements of which are discussed under the various headings in this paper.

Qualified privilege

Qualified privilege refers to the problem that has emerged when clinical professionals seek to discuss openly patient cases or data with a view to improving how things are done. In doing this, the clinical professionals involved may be reluctant to discuss critically what occurred as the information generated might become disclosable in subsequent legal proceedings. Australian and international jurisdictions have legislated for committees undertaking continuous improvement activities of this kind to be granted legal privilege under qualified conditions. This means the information drawn up in support of the committee review process is not disclosable. It strikes a balance between the ordinary right of individuals to access information about them and the necessity to create documentation which cannot be accessed by patients or their legal representatives, and which is suitably detailed for review purposes in clinical settings.

Quality assurance

As discussed, quality assurance is an older term which has been discarded in many organisations. The connotation of somehow guaranteeing quality is not seen as feasible today. However, the sentiment, that Boards, managers and clinicians should at all times pledge to do all they can to maintain quality standards, is one to which most people would agree.

Continuous education

Just as there is a recommended approach to promote continuous improvement of services and the quality of care, there are many systems in place to encourage staff to engage in continuous education. Lifelong learning is a desirable individual characteristic but at the organisational level it is important that this is an entrenched cultural characteristic. There are many reasons why this is crucial, but a core consideration is that the knowledge explosion is occurring in every discipline. It is incumbent on individuals and organisations to strive to keep pace with this, and continuously-learning individuals and organisations will be exposed to new practices, technologies and ideas which can be exploited for the benefit of health professionals and the services they provide, thus contributing to clinical and organisational improvements. Boards and executives can help establish the lifelong learning agenda in many ways, including taking a lead in personally embracing continuous education, valuing education for others and promoting openings for people to participate in appropriate and relevant educational and learning opportunities.

A focus on ethics

Another way to think about governance is to say: to deliver appropriate care within budgetary allocations in a timely way to patients without harming them is an ethical issue. Boards and executives need to act in fiscally responsible and ethically appropriate ways, and they need to sponsor such values throughout the workplaces for which they are responsible. Clinical practice is an ethical minefield at times (who gets what, under what circumstances, according to what criteria?) and, again, this means governing bodies need to be highly vigilant and constantly promoting appropriate values and standards.

Planning and organising governance structures for safety and quality

Fostering positive attitudes sets up the ethical and philosophical foundations for clinical governance. The enactment of clinical governance, however, is dependent upon effective planning and management. In this section, we review some types of governance structures and strategies which support the principles of safety and quality.

Managing performance

Good management practice suggests that the performance of individuals and groups needs to be reviewed at regular intervals and aligned with the overall organisational mission. Performance

management seeks to align organisational goals with group and individual goals. It provides feedback on performance progress within an appropriate framework. Ideally, an effective performance management system covers what is being achieved, how it is being achieved and the extent to which people are meeting their goals. It is a developmental and encouraging, rather than a punitive or disciplinary, tool. Although there are many different systems, performance management typically enables joint discussions and agreements to be brokered on performance matters, goals and progress between an employee or group of employees and the person responsible for that employee or group of employees.[40-42] The role of boards and executives is to ensure that relevant systems are in place and to provide leadership by participating in the performance management of those on the direct reporting line to them.

Managing risk

The Victorian Managed Insurance Authority sees risk and its management this way: "Risk management is a logical and sequential approach taken to identify risks, quantify their impacts and manage them within defined acceptable limits".[43] There are various kinds of risks in health care, including organisational, financial, occupational health and safety, plant and equipment and patient safety risks. In the context of clinical governance and the various inquiries into adverse events,[7] there are considerable risks to patients under a board's care, particularly given the complexity of contemporary health treatments and interventions. It is incumbent on boards and executives to make sure that an effective risk management plan is developed and operationalised in their health care organisation.

Reporting and managing critical incidents

The inquiries into what can go wrong in acute health settings, such as at Bristol,[6] Campbelltown and Camden,[9] King Edward Memorial Hospital[8] and Bundaberg[10] have shown that every board and executive group should be sensitive to the possibility that they will encounter a critical incident or crisis, either of a clinical or more general nature. There needs to be a regular review and reporting process of critical incidents and potential critical incidents to the Board and executive group. Sometimes, provider organisations encounter a substantial, even dire, incident. Despite having a regular reporting process, if and when it occurs this will almost always be unexpected to some degree, and typically will stretch the organisation's capabilities beyond normal limits. It is also the case that a critical incident can take considerable time, resources and effort to deal with, and, if a major inquiry is set up to investigate it or it becomes political or subject to sustained media interest, can paralyse the organisation, with adverse effects sometimes lasting for years. The first task is to make sure that patients, their relatives and staff, depending on the nature of the incident, are looked after. Boards and executive groups need to be sure that they have a clear plan for dealing with the incident itself, and also for handling the political and media interest. Other key stakeholders are the bureaucrats in health agencies, the public, patients and relatives, unions, Colleges, relevant administrative and judicial bodies and other representative groups. All must be managed if a serious incident is encountered.

Credentialling medical practitioners

The Australian Council for Safety and Quality in Health Care (now the Australian Commission on Safety and Quality in Health Care) commissioned work completed in 2004 on credentialling medical practitioners. It sought to strengthen processes of credentialling staff and define the scope of clinical practice. According to the report the goal is "to ensure that care is provided only by qualified professionals whose performance is maintained at an acceptable level".[44] The report argued that "The processes of credentialling and defining the scope of clinical practice must ... change, to enable health care organisations to be confident that health care professionals' performance is maintained. Ongoing performance is not, however, the sole responsibility of health care professionals. It also relies on support being

provided by health care organisations to the extent necessary to enable safe, high quality practice." Boards and executives have clear responsibilities to provide that support and fulfill credentialling requirements.

Applying standards

There are many standards in health care — for individuals, for services and for organisations. One prominent example is the EQuIP program of the Australian Council on Healthcare Standards.[45] It specifies various standards which health care organisations must meet according to predetermined criteria in order to satisfy requirements. Standards are usually evidence-based, and designed to be consistently applied across many different kinds of organisation or professional group. Boards and executives should ensure that their organisation participates in appropriate accreditation processes.

Participating in accreditation processes

Accreditation is the systematic application of predefined standards and criteria in order to assess the performance of an organisation, institution or entity. In health care this typically involves several phases such as completing self-assessment documentation, being visited by external experts (accreditation surveyors) and documenting performance against clinical indicators. Accreditation standards and criteria are constantly evolving, and thus the benchmark against which standards are assessed is constantly being raised. This introduces a measure of continuous improvement into accreditation processes and organisational performance. Boards and executives should support efforts to participate in accreditation and should ensure that sufficient resources are available to make the participation worthwhile.

Organising and using data and evidence

While ethical and structural responses to quality and safety are central to appropriate implementation of clinical governance, the sharing of data, knowledge and expertise are essential to its effectiveness, and the effectiveness of health services as a whole. In this section we explore current approaches and systems for the sharing, management and development of knowledge in health services.

Improving the sharing of information

Information is power, says the old aphorism. Health care organisations are typically swimming in data, but this does not necessarily mean that it has been aggregated into good, usable, valid and reliable information. Even more scarce is robust intelligence. Turning data into information and intelligence is a challenging task in health care environments. Data sources include those from the inpatient and outpatient collections, aged care sources, health status and profiles of clients, organisational activity data, human resource management systems and financial and accounting charts and cost centre aggregations. Data need to be synthesised and formatted so that users at departmental, divisional, organisational, executive, board and regional levels are provided with suitable reports on which to base timely decisions. Few organisations have tackled this such that decision makers feel comfortable that the information available to them provides an accurate, comprehensive picture of organisational and clinical performance. Although this is likely to be a long-term project for most health care organisations, boards and executives should support the journey of improvement in data management and reporting, and develop ways to encourage decision-making groups at all levels to use and share information.

Encouraging clinical effectiveness

At its simplest, clinical effectiveness is about striving to ensure that practice is based on the best available data and evidence. Glanville and colleagues put it this way: "Clinicians will need to be able to access information on clinical effectiveness in order to improve the quality of care and to stay well informed on developments in specialist areas."[46] (p. 200) Although this is much more difficult than it seems, largely because of the complexity of patient care and the lack of or

equivocality of some research evidence, it is nevertheless the case that boards and executives will need to put in place measures that support the ongoing education of clinicians and encourage them to keep informed about developments in their specialty area.

Promoting evidence-based practices

Closely allied to the idea of encouraging clinical effectiveness is the concept of evidence-based practice. This has mostly been discussed in the context of medicine, but more recently other health professions have increasingly embraced evidence-based approaches. Sackett and his co-authors defined it, and argued for its importance, as follows: "Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research".[47] (p. 71) On this view there are two distinct aspects of evidence-based practice: individual clinicians making effective decisions in their treatment and intervention regimes, and the research-based evidence available to them. Sackett et al went on to say: "Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients". (p. 72) The role of boards and executives is to ensure that supportive structures such as access to online evidence are in place to enable clinicians to keep abreast of the evidence and to promote at every opportunity the importance of both effective practice and the systematic use of evidence as two sides of the equation.

Using clinical indicators

There are clinical indicators at various levels in health care including organisational-wide indicators, and indicators for specific specialties and sub-specialties. They can be used to map performance of a particular unit or organisation over time or to benchmark performance, say with another local provider or one with an international reputation for the highest quality services. Boards and executives need to know about the range of indicators that are available, and might seek to be assured that they are being used to monitor internal performance or benchmark against external comparative providers. High-level clinical indicator data should be reviewed regularly by boards and executive groups in order to track organisational and clinical performance and progress.

Using audit

Clinical audits are assessments designed to improve care. A frequently used definition of audit from the National Institute for Clinical Excellence in the United Kingdom is: "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery".[48] While clinical audit is led by clinicians, boards and executives should ensure that regular and widespread clinical audit activity is occurring throughout health care organisations within their ambit of responsibility.

Managing knowledge effectively

Although discussed earlier under the headings *Improving the sharing of information* and *Promoting evidence based practices*, ways must be found by which to manage knowledge effectively. In any complex health care setting there are various sources of data, and a movement is underway in many health care organisations to base clinical and organisational decisions on the best available evidence and information. Knowledge management approaches involve actively striving to pro-

mote the sharing and use of information or the adoption of new ideas, ways of working or technology. According to Rogers[49] and Sanson-Fisher[50] there are five elements which together determine how and whether adoption or diffusion of a new activity will occur. These are: relative advantage (is it a better idea or practice than that which exists now?), compatibility (does it fit with the existing circumstances?), complexity (is it too complicated for our needs?), trialability (can it be piloted and modified, to fit our purposes?) and observability (can we see it working well in our environment?). Boards and executives might find this a useful model for determining what new ideas, practices or technologies they may be willing to approve or embrace.

Sponsoring a patient focus

In this final section, we turn to the commitment to patient-centred care that boards and executives need to endorse. Health services should be demonstrably committed to open and effective communication with patients. The role of the board and executives is to foster a patient-focused approach, and oversee strategies which ensure the rights and involvement of patients.

Encouraging consumers to participate in decisions affecting their care

There is a very strong reason for encouraging consumers to participate in decisions affecting their care: at the end of the day, the health care system is their system and the care that it provides affects them in intimate and personal ways. The United Nations' Department of Economic and Social Affairs has produced guidelines which argue for the primacy of the consumer in all walks of life.[51] In health care, it is critical not merely to obtain patient consent in a mechanistic or superficial way, but, over the long term, to redesign the health system such that consumers are more educated and informed about decisions affecting them. The consequences of failing to do this are untenable, as it will mean perpetuating the paternalistic, hierarchical modes of working which prevailed in the past. Boards and executives have a role to play in supporting structures, approaches and attitudes to encourage consumers to participate and health professionals to operate in joint decision-making modes with patients.

Focusing on patient safety

Given all that has been researched and written about health care management, quality and safety, it would be easy to think that service providers are patient focused and mindful at all times of patient safety. This is not necessarily the case. Just as there should be a clear plan for reporting and managing critical incidents and a plan for managing risk, so there should be a concerted effort and organised approach to focusing efforts on patient safety. One structural suggestion is to organise clinicians into groups of patient-focused service configurations, commonly known as clinical streams or clinical directorates.[52,53] Another approach is to organise care with a safety first approach in mind.[54]

Supporting open disclosure

According to the National Open Disclosure Standard developed by the Australian Council for Safety and Quality in Health Care, disclosure "refers to open communication when things go wrong in health care. The elements include: an expression of regret; a factual explanation of what happened; consequences of the event; and steps being taken to manage the event and prevent a recurrence".[55] It is incumbent on boards and executives to have appropriate policies and practices, well publicised and instituted widely, to support and promote open disclosure.

Obtaining patient consent

There are policies and procedures in all Australian jurisdictions which require appropriate patient consent to have been obtained and any disclosure of material risk to have been made before treatment being initiated. Boards and executives need to take these responsibilities seriously as there is substantial exposure to legal risk involved both to attending practitioners and to health care organisations if consent has not been obtained or disclosure not made. For practitioners, liabilities include pos-

sible findings of negligence or breach of duty of care owed to the patient. Individual practitioners can be liable for damages, action in battery or even criminal sanctions.

Dealing with complaints effectively

More recent approaches to handling patient complaints have suggested that an active, collegiate manner and an open, forthright willingness to engage with the complainant can yield many benefits. The Australian Council for Safety and Quality in Health Care commissioned a handbook entitled the *Complaints management handbook for health care services.*[56] The traditional approach to dealing with complaints in the health care sector was to avoid them or manage them separately from other risk management and compliance issues. Under this approach the investigation of complaints examined only what happened, not why, with a focus on the individuals directly involved rather than the systems of care. The *Complaints management handbook* argues that "the quality improvement approach to handling complaints has a number of elements: actively encouraging feedback from consumers about the service; negotiating with consumers about outcomes and not just 'telling them'; managing complaints as part of risk management, enabling appropriate reporting, assessment and follow up action; and learning from complaints and consumer feedback, enabling improvements to the systems of care". (p. 6) Boards and executives have a role to sponsor an appropriate complaints-handling system and to support efforts to deal with complaints effectively and judiciously.

Discussion

From the foregoing we can see that there are many policies, practices and initiatives which can be harnessed and promoted in support of a well-rounded approach to clinical governance. We have discussed the considerable responsibilities which boards and executives have in enhancing health systems through clinical governance approaches. Strategies of this kind are in train in many Australian health sector workplaces and organisations, but experience suggests that most have a long way to go in enacting clinical governance in the comprehensive way we have described here.

It has been the purpose of this paper to highlight the role of boards and executives in sponsoring and endorsing clinical governance approaches. As discussed, this may be a relatively recent idea, but few would doubt that clinical governance is also central to fashioning appropriate clinical care and organisational responsiveness. At the end of the day this is about working toward clinical and organisational excellence. No board or executive group should want to settle for anything less.

Further recommended reading

During the discussion of a clinical governance approach to health care delivery, various documents, articles and websites have been cited. A more comprehensive reference list is available on the Centre for Clinical Governance Research website at: http://www.med.unsw.edu.au/medweb.nsf/page/ClinGov_Monographs and some useful sources are provided here.

Clinical governance and quality and safety websites

- Agency for Healthcare Research and Quality http://psnet.ahrq.gov/
- Australian Commission on Safety and Quality in Health Care http://www.safetyandquality.org/
- Australian Healthcare and Hospitals Association http://www.aushealthcare.com.au/
- Australian Patient Safety Foundation http://www.apsf.net.au
- Canadian Patient Safety Institute http://www.patientsafetyinstitute.ca/index.html
- Centre for Clinical Governance Research in Health, University of NSW http://www.med.unsw.edu.au/medweb.nsf/page/ClinGov_About
- Institute for Healthcare Improvement http://www.ihi.org/ihi
- The International Society for Quality in Health Care http://www.isqua.org.au

- The Joint Commission http://www.jointcommission.org
- National Institute of Clinical Studies http://www.nhmrc.gov.au/nics/asp/index.asp
- National Institute for Health and Clinical Excellence http://www.nice.org.uk/
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Academic journals

- Australian Health Review http://www.aushealthcare.com.au/publications/articles/index.asp
- Asia Pacific Journal of Health Management http://www.achse.org.au/journal/journal_body.html
- British Medical Journal http://bmj.bmjjournals.com/
- Clinical Governance: an international journal http://www.emeraldinsight.com/Insight/viewContainer.do?containerType=Journal&containerId=11310
- Clinical Governance Bulletin http://www.rsmpress.co.uk/cgb.htm
- International Journal for Quality in Health Care http://intqhc.oxfordjournals.org/
- International Journal of Health Care Quality Assurance http://www.emeraldinsight.com/info/journals/ijhcqa/ijhcqa.jsp
- Journal of Clinical Governance http://www.le.ac.uk/cgrdu/jclingov.html
- Medical Journal of Australia http://www.mja.com.au
- Quality and Safety in Health Care http://qhc.bmj.com/

Australian jurisdictional websites

- ACT Health http://www.health.act.gov.au/c/health
- Department of Health and Ageing http://www.health.gov.au
- Department of Health and Human Services, Tasmania http://www.dhhs.tas.gov.au/
- Department of Human Services, Victoria http://hnp.dhs.vic.gov.au/wps/portal
- NSW Health http://www.health.nsw.gov.au/quality/

- Northern Territory Department of Health and Community Services http://www.health.nt.gov.au/
- Queensland Health http://www.health.qld.gov.au/clinicalgov/default.asp
- South Australian Department of Health http://www.health.sa.gov.au
- Western Australian Office of Safety and Quality in Health Care http://www.clinicalgovernance.health.wa.gov.au/home/index.cfm

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