

CLINICAL GOVERNANCE

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Bulletin

Editorial: Complaints

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Over the past 10 years, patients' expectations of the NHS have increased enormously. While the majority of patients are satisfied with the care they receive, too many still have a bad experience when they come into contact with the NHS, and a few of them complain. Complaints are a source of stress for both complainants and staff. It is therefore important that they are dealt with quickly, that lessons are learnt from them and that action is taken to prevent their recurrence.

So how should one *deal with complaints*? All NHS organisations will have in place a process which follows the guidance for the implementation of the NHS complaints procedure¹. It is important that complaints are dealt with promptly, that the questions raised by patients are answered, and that patients are given a clear and full explanation; this will reassure them that the issues have been taken seriously and that any shortfall in the quality of care has been identified and will be remedied.

Always be honest and do not hesitate to apologise when appropriate.

Can we *learn from complaints*? Complaints offer valuable information about the patient experience within the health-care system. The content of complaints should be logged on a database by clinical teams so that trends can be monitored and action taken when needed. This information should regularly be made available to the relevant clinical teams, considered at their governance meetings, reviewed with other sources of information, debated, and areas for improvement identified and agreed; the team can then identify who should implement the changes required and stipulate the time scale. The overall changes should be reported and monitored by the organisation's governance committee.

It is important that compliments received are also considered; unfortunately, few organisations have in place a process to capture these, and this is an issue organisations should address. Praise of the service from other patients may well make a difference to complainants' attitudes when they are considering whether to take further action.

Can *complaints be prevented*? Not all complaints can be prevented. However, they can be minimised if patients are given clear information, always involved in the decision about their care, given a genuine choice, kept up to date with their care plan and treated with respect. Staff also need to be equipped with skills which enable them to handle the

Topics for future issues

- Clinical audit
- Clinical networks
- International perspective on quality assurance

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queries and concerns of patients and their families. A complaints awareness and customer care training programme should thus be mandatory for all staff. The training programme should ensure that staff understand the complaints process and the need for effective communication; they will also need to learn to see the 'world' from the patient perspective and learn how to deal with difficult people.

Can complaints be used in performance monitoring? In major systematic failures that have made national headlines, warning signs have often been present before the patient(s) suffered significant harm. This has led to the need to monitor clinical performance more closely and identify poor performance early so that remedial action can be taken^{2,3}. It is therefore incumbent upon the NHS to use the information available to such an end. Complaints are one element to be used in monitoring clinical and managerial practice to identify areas of concern early; other sources of information include clinical indicators, untoward incidents and audit results. Not only should complaints be discussed as part of the directorate's performance review, but they should also be discussed at individuals' appraisals, to inform their personal development plan.

In this issue we are addressing the issue of complaints and what can be learnt from them. In future issues we will cover clinical audit, clinical governance in clinical networks and have an international perspective on the quality agenda. We would strongly encourage you to share your experience in the field of clinical governance with the wider NHS, as we are keen to ensure that lessons you have learnt can benefit others. So please put pen to paper on any topic related to clinical governance.

References

- 1 Hobbs S. Learning from complaints. In: Ligon M, Secker-Walker J, eds. *Clinical Governance. Making It Happen*. London: Royal Society of Medicine Press, 1999: 117-30
- 2 General Medical Council. *Revalidating Doctors. Ensuring Standards, Securing the Future*. Consultation Document. London: GMC, 2000
- 3 *Supporting Doctors, Protecting Patients. A Consultation Paper on Preventing, Recognising and Dealing With Poor Clinical Performance of Doctors in the NHS in England*. London: Department of Health, 1999

Can we learn from complaints? A case study

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- **Listening to complainants is important if we want to deliver patient-centred care and learn from our patients' experiences.**
- **Complaints need to be examined and result in real change, such as amending policy, procedures or processes to improve patient care.**
- **A complaint affecting many teams may be a catalyst to move the clinical governance agenda forward and address the special needs of particular patient groups, such as children.**
- **Feedback to complainants about the changes effected is necessary to reassure them that improvements have been made.**
- **An immediate apology is not an admission of guilt and will often diffuse a damaging situation.**

Why do people complain? Because the service provided does not meet their expectations and they want the 'powers that be' to know, so that something gets done about it.

The first thing they want is an apology, or at least an acknowledgement that they have a justified point. The second thing they want is for something to be changed, so that they or others do not have the same experience again.

When we receive a complaint, there are two actions we have to take:

- first, respond promptly to the complainant with an apology or at least an explanation;
- second, embrace the complaint as an opportunity for learning.

It is important to separate these two actions clearly. They do not have to occur in the same time frame. After an apology, if the complainant believes you, as an organisation, will learn from the complaint and improve practice, then both patients and staff will believe the complaint has been worthwhile.

Feedback is crucial. If you tell complainants you are going to do

something, make sure you get back to them to confirm the action has been taken. In this way you can turn an adversary into an ally.

Our experience

The following event was a great learning exercise in our trust; it proved that complaints really are a rich source of information and a powerful catalyst for change.

We received a complaint from a young couple who were angry that there appeared to have been unnecessary delays in their 17-day-old son having surgery for pyloric stenosis. The baby was admitted unwell and vomiting on Monday. Two days later it became obvious he had a pyloric stenosis. A referral was made to a consultant surgeon. However, the senior anaesthetist considered the baby to be unfit for surgery due to abnormal blood biochemistry, which could compromise recovery. Over the following three days, the operation was arranged and cancelled twice. On the fifth day the baby was transferred to a tertiary centre, and was operated on the same day. During the baby's stay, three paediatricians, two surgeons and one anaesthetist cared for him. Although it was recognised that all the clinicians were acting in the baby's best interest at the time, the quality of care was obviously not satisfactory. No clinician appeared to have overall responsibility for the baby and this led to the parents receiving conflicting clinical advice.

We spoke to the parents, who were justifiably annoyed by a saga of well intentioned staff acting individually in the child's best interest. The opportunity for patient-focused multidisciplinary team working was missed. This was compounded by the absence of protocols and guidelines, and a lack of effective audit of outcomes of what appeared to be a relatively infrequent event.

After sitting down with the parents, which was a very humbling

experience, we agreed that we could do it better and we would make sure we did so.

What actions should we take?

The first thing was to get the key players together to discuss how to improve the situation. It soon became apparent that although this had happened in general paediatric surgery, there was no reason why the event should not be replicated in the other surgical disciplines that had patients on the children's unit. We therefore agreed on a trust paediatric surgical policy. This defines, by age group, what type of surgery should be carried out at a district general hospital, and whether the surgery should be performed by a surgeon and anaesthetist with a special interest in paediatrics. Responsibility for a patient at any particular time in the hospital stay is defined. This may change from paediatrician to surgeon, depending on the stage of treatment.

The policy also needed to define what would happen if a surgeon capable of performing the surgery was not available – that is, a transfer policy. This required us to share the policy with the regional children's hospital, to get its agreement.

At this stage we wrote back to the couple to explain that, as a result of their complaint, we had put in place a policy to ensure others would not have the same experience.

However, a policy is no good unless it is 'policed'. This was when we realised what had been missing in the first place. There needed to be a multidisciplinary forum in which to discuss the practical problems of implementing and maintaining the paediatric surgery policy. The Paediatric Surgery Group was therefore formed, chaired by a lead paediatric surgeon, with anaesthetic, paediatric, nursing and clinical governance input. There is no patient representative as yet, but we are working on this.

What does this group have to discuss? Well, we now have an ongoing audit of all paediatric surgery against the policy and we review all paediatric surgery clinical incidents.

This is 'joined up' clinical governance working to best effect: patient feedback, protocols/guidelines, risk management and training within a culture of multidisciplinary working.

Auditing complaints

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- Random audit of complaint letters can assist in identifying trends and targeting where action needs to be taken to improve practice.
- Poor communication, staff attitudes and quality of care were identified as major themes of both nursing and medical complaints.
- Complaint response letters often failed to give an apology for the event complained of.
- Carrying out this audit has helped the trust identify training needs and make changes to our complaint management practice.

A retrospective audit of over 200 medical and nursing complaints was undertaken at Aintree Hospitals NHS Trust during 2000. The data were analysed by grouping components of complaints into themes. The audit clearly identified areas of concern for both nursing and medical staff, with the principal issues for both being related to communication, attitude of staff and quality of care.

The results were broken down into four sections:

- who complains and when
- specific nursing themes
- specific medical themes
- how complaints are responded to

The majority of complaints are made by the patients themselves or the children of elderly patients. For complaints related to nursing, the patient's children were far more likely to complain than the patient.

Table 1. The six major themes of nursing complaints, as a percentage of all nursing complaints

Main theme of complaint	Proportion of complaints
Fundamentals of nursing care	54%
Attitude of nursing staff	20%
Communication	15%
Environment	7%
Documentation	2%
Discharge	2%

Six major themes emerged from analysis of the nursing complaints (Table 1). Within each of these major themes there was a series of subthemes. For example, communication could be subdivided into three subthemes:

- communication between professionals
- communication with patients
- communication with relatives

Fifty-four per cent of the constituent components within all of the nursing complaints were related to the 'fundamentals' of nursing care; this theme was broken down into 16 components, including feeding, washing, privacy and dignity, and pain control.

Three major themes were identified for medical complaints (Table 2). Half of all medical complaints were related to aspects of clinical treatment and were broken down into a series of nine components, including clinical decision making, pain control, poor assessment and drug prescribing.

Although clinical decision making is an area of concern for complainants, in the main it would seem that they were not complaining about the decisions made but rather about the failure to communicate these decisions and the rationale behind them.

For each complaint audited the corresponding response was also reviewed. Responses to nursing complaints were far more likely to offer apologies than responses to medical complaints. Responses to nursing complaints included an apology 68% of the time, compared with 47% of

Table 2. The three major themes of medical complaints, as a percentage of all medical complaints

Main theme of complaint	Proportion of complaints
Communication	26%
Clinical treatment	50%
Attitude of medical staff	24%

responses to medical complaints. The same was true for accepting responsibility for the complaint, with 41% of responses to nursing complaints accepting responsibility compared with only 24% of responses to medical complaints.

Following this audit, the trust has made a number of changes to practice, with the aim of improving complaint handling and customer care:

- A new tool for coding complaints has been adopted so that they are broken down into more detailed themes; these are then fed back to all managers through a quarterly clinical governance report.

- There are now more customer care courses, and these incorporate the issues raised by the audit.
- A course on answering written complaints is delivered to all clinical service managers.
- A follow-up form has been developed which managers must complete to indicate action taken and lessons learned following each individual complaint.
- New systems for patients and relatives to voice concerns have been developed. These include: a Patient Advocacy and Liaison Service (PALS); a patients' comments system; a patients' satisfaction survey.

- The trust is taking part in the national 'Essence of Care' benchmarking exercise, looking at the fundamental aspects of nursing care.

The process of reviewing complaints, learning lessons and changing practice is ongoing. A number of projects related to improving complaint management are currently under way at the trust and it is hoped that, over time, this reflective developmental approach to learning from our mistakes will lead to better handling of written complaints and an overall reduction in the total number received.

Guiding principles for managing complaints

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Complaints should not be seen as the sole responsibility of a corporate department. With increasing emphasis on personal accountability, everyone in the organisation needs to contribute to handling them effectively, improving performance in complaints management and learning lessons from them.

Handling complaints properly is an important part of good customer care. It shows that you:

- listen to your users' views
- learn from your mistakes
- are continually trying to improve your service

Ensure that access to the complaints procedure is simple and understood. It must:

- encourage complaints and compliments by advertising your procedures and making them easy to use
- inform all your users about your service standards and how to comment if you do not meet them
- make it clear that you welcome complaints and comments and that you will use the information to improve your services

- make you think about providing a service for users who have special needs, for example those with a reading, hearing or language difficulty
- enable you to audit the procedure regularly

A good idea is to enhance support for staff by putting together 'survival' kits on handling complaints at ward/department level. Such a kit should:

- encourage front-line staff to 'own' complaints
- give staff immediate access to clear, written procedures that focus on sorting out complaints quickly
- provide immediate support for staff – in particular, for new or locum staff

But one must remember the following:

- consult staff and users when drawing up and revising complaints procedures
- make sure that the procedures are fair to staff and users, and that information is treated as confidential
- recognise the importance of good communication skills when recruiting and training staff who handle complaints
- make sure that all staff know about the policy and receive training

- draw up a menu of remedies and make sure that staff and users understand options, including the role of the ombudsman
- support your staff, which in turn will improve their commitment to handling complaints properly
- get the basics right – listen carefully and investigate properly

Complaints and performance management

- Record all complaints and analyse them regularly to understand users' views and the improvements they want to see.
- Establish an effective complaints monitoring group, preferably with membership from the community health council, or other patients' representatives.
- Collate regular reports for management teams, looking at trends and changes in the pattern of complaints, which may arise as a result of changes in service delivery or configuration.
- Report formally at least quarterly to the board.
- Publish information in the annual report, or equivalent, on: trends; issues for complaints management; lessons learnt.
- Pass information from complaints monitoring to policy makers.
- Take advantage of new technology.
- Subject complaints monitoring to peer review.

This article is an extract from 'Learning from complaints'. In: Ligon M, Secker-Walker J, eds. *Advancing Clinical Governance*. London: Royal Society of Medicine Press, 2001: 81–98

Top tips for managing complaints

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Preventing complaints

- Induction is crucial. Train all members of staff, from induction on, to spot possible problems and stop them from turning into complaints. Staff who pool information about concerns mentioned by patients and their relatives have a better chance of addressing misunderstandings and worries, which are common sources of complaint. Induction for agency staff (e.g. briefing notes provided via recruitment agencies or on arrival) and for staff on rotation (senior house officers, specialist registrars, professionals allied to medicine in training) require the special attention of senior staff, especially course and programme organisers, and contracts managers.
- Continuing education is also crucial. The causes of complaints are well known: failures in communication and understanding (between professionals and both other professionals and patients and families); lack of information before and after episodes of care; and poor housekeeping standards. These all feature in trust board papers and practice discussions about complaints – and ombudsman reports¹. Use them all to construct case studies and make these issues live for all staff – new staff, staff in training and the senior staff who teach them.

Handling complaints

Remember, most people *do not* complain, and those who do have given it serious thought. Overwhelmingly, people want:

- to be taken seriously
- a clear and full explanation of the events complained about
- an apology, if necessary
- action to prevent the same thing happening to anyone else
- a full response within a reasonable period of time

If a complaint is made about you:

- try not to take it personally (complaints are often not a personal matter at all)
- take it seriously
- try to recall everything you can about the events complained about and write the details down
- if you are not sure what the complaint is all about, *ask* – the complaints manager, your boss, the practice manager
- decide whether you would like the advice of your professional body

If you are managing a complaint, do all you can to achieve a resolution.

A response must be more than a description of the events as you see them. Offer a face-to-face meeting, but remember that decisions about timing, location and participants can be vital. Involve a conciliator. Draw on demonstrably independent advice as early as possible.

Reference

- 1 www.ombudsman.org.uk

Editorial Committee

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Contributions

Contributions that are practical and relevant to everyday practice are welcomed. They should be 500–800 words in length, with a maximum of five references in Vancouver (numerical) style. Please send your contribution, by post (with floppy disk) or email, to: Dr Myriam Lugon, Editor, *Clinical Governance Bulletin*, c/o Royal Society of Medicine Press Limited, 1 Wimpole Street, London W1G 0AE (email MLugon@compuserve.com)

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WhoWhatWhere?

Complaints on the web

The Editors' Choice

The Health Service Ombudsman

<http://www.ombudsman.org.uk/hse/index.html>

The Health Service Ombudsman investigates complaints about the NHS. This website gives you a general outline of the procedures.

Government sites

NHS complaints procedure in Scotland

<http://www.show.scot.nhs.uk/publications/me/complaints/>

Complaints procedures for the Department of Health

<http://www.doh.gov.uk/complain.htm>

Evaluation of the complaints procedure

<http://www.doh.gov.uk/nhscomplaintsreform/evaluationreport.pdf>

Annual review of complaints – Eastern Health and Social Services Board

<http://www.ehssb.n-i.nhs.uk>

Other sites

South London and Maudsley Trust.

Annual report, 2000–1: complaints
<http://www.slam.nhs.uk/news/anreport/16.asp>

Velindre NHS Trust. Report, 2001

[http://www.velindre-tr.wales.nhs.uk/pdf/Complaints Annual Report 2000-2001.pdf](http://www.velindre-tr.wales.nhs.uk/pdf/Complaints%20Annual%20Report%202000-2001.pdf)

Analysis of complaints survey, Vanderbilt University Medical Center in Nashville, TN, USA

http://www.ahcpub.com/ahc_root_html/hot/archive/psom0399.html

Ambulance Service Association. Clinical governance in the NHS ambulance service. Reference pack
<http://www.asancep.org.uk>

Measuring patient experience

<http://www.pickereurope.org>

Why not email us your suggestions?

If you know of any useful websites that you would like us to mention in *Clinical Governance Bulletin*, please email kirsty.orriss@rsm.ac.uk.

Learning the lessons from Bristol

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- The publication of clinical indicators based on individuals' performance requires robust clinical information.
- Professional self-regulation must be multidisciplinary and firmly linked to education and professional development.
- The continued development of a patient-centred approach and an emphasis on patient safety remain priorities, and will need to be underpinned by a series of guidelines.
- Front-line staff will need to take on more responsibility.

In the previous issue of the *Bulletin*¹, we reviewed the national approach to patient safety and discussed the recommendations of the report of the Bristol Inquiry². The Department of Health's response, *Learning from Bristol*³, announces many changes but also confirms the direction for the NHS:

- greater participation and involvement of patients and the public
- a continued focus on patient safety
- more scrutiny of clinical performance and managerial practice
- greater professional regulation
- major changes in education and training

The relationship between the government, the NHS and its patients is changing, with devolution of responsibility to front-line staff and more independence given to statutory organisations such as the Commission for Health Improvement (CHI).

What changes can we expect?

We can expect a reinforcement of the patient-centred approach, with:

- better comparative information on local health services

- the establishment of a National Knowledge Service for the NHS, which will operate from April 2003 to 'support the delivery of high quality information for patients and staff'³
- the publication of the 'reformed' NHS complaints procedure by the end of 2002
- the publication of a code of practice on communicating with families about postmortem examinations
- the publication of guidelines about sharing information with patients
- confirmation that a Patient Advice and Liaison Service will be in place in every trust from April 2002
- the establishment of a citizens' council by the National Institute for Clinical Excellence (NICE)
- the creation of the Commission for Patient and Public Involvement in Health (CPPIH), a new national body for patients to

'oversee the local structures for public and patient involvement'³

We can also expect a more explicit framework for setting, delivering and monitoring standards, by strengthening and extending the role of both CHI and NICE:

- CHI will be given more independence, as stated in the recent health-care bill put before Parliament.
- An Office for Information on Health-Care Performance will be established as part of CHI, with responsibility for monitoring 'clinical performance' and publishing reports on performance indicators.
- CHI will be given both a more 'inspectorial' role with regard to service providers and the authority to take swift action when significant problems are identified or when patients' safety is compromised.
- CHI will publish an annual report on the quality of services within the NHS, which will be laid before Parliament.
- NHS bodies will be directed to fund treatments recommended by NICE.
- NICE will be empowered to disseminate its recommendations without the prior approval of the Secretary of State for Health.

Patient safety focus

A commitment has been made to ensure patient safety, by minimising the number of adverse events. This will be achieved by greater emphasis being placed on the introduction of new techniques. NICE is given responsibility to provide the 'oversight and scrutiny needed for the introduction of new interventional procedures'³. Guidance will be published for NHS trusts to ensure that new techniques are introduced safely. A white paper to be published in 2002 will outline improvements to the process for dealing with claims of clinical negligence. The National Patient Safety Agency (NPSA) will of course need to fulfil its work programme described in *Building a Safer NHS for Patients*⁴, such as a single national system for reporting adverse events and near misses, analysis of the data collected to identify lessons which can be disseminated to the wider NHS, and development of guidance on root cause analysis. Furthermore, work will be undertaken with the Design Council 'to identify oppor-

tunities for design solutions to safety problems'³.

Professional self-regulation

Strengthening professional regulation and changes to education and training are also on the agenda. The relevant measures will include:

- the establishment of a new Council for the Regulation of Health-Care Professionals
- wider access to medical schools
- more involvement of the public in the selection of potential health-care professionals
- a new curriculum in medical schools
- more priority to non-clinical aspects of care in education, training and professional development
- new guidance on disciplinary procedures
- a new contract and code of conduct for senior managers

Monitoring performance

A commitment has been made to the development of effective monitoring of the quality of care, by making better use of the information contained in Hospital Episode Statistics and by publishing data on the clinical performance of consultants and their teams; this will start with the publication of 30-day mortality rates for every cardiac surgeon by April 2004. It also includes the establishment of a directory of clinical audit databases and the development of national audits for NHS clinical priorities.

Conclusion

Learning from Bristol reiterates the changes announced in the NHS Plan and reminds the readers of the Prime Minister's four principles of public sector reforms³:

- high national standards and clear accountability
- devolution of power and resources to the front line, to give those professionals who deliver services the freedom to innovate
- increased flexibility for staff to cut across outmoded professional barriers
- a greater range of alternative service providers and choice for the patient

The role of the new national bodies (the Council for the Quality of Health-Care, the Council for the Regulation of Health-Care Professionals, and the CPPIH) will need to be made explicit and attention will need to be given to their relationship with the organisations which have been created over the last two years, if we are to avoid confusion and duplication.

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- 2 <http://www.bristol-inquiry.org.uk>
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Directorate-based clinical governance – introduction of a standardised reporting template

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- The clinical governance reporting system implemented in trusts should be flexible enough for use by all directorates.
- A structured system can facilitate the preparation of trust-wide clinical governance reports.
- The system should allow for free discussions of overlapping issues, while focusing responsibility clearly on the directorates.
- The system should facilitate constructive feedback and raise awareness of clinical governance.

Purpose of the template

When our trust performed a baseline assessment of clinical governance, before it began to implement it, it became clear that the majority of the necessary structures and processes for clinical governance were already in place. However, there were weaknesses and a general lack of cohesion. The reporting template was designed to address these weaknesses and pull processes together; it put responsibility for this on one individual, the general manager, and it focused clinical governance firmly within the directorates.

Contents of the template

The key areas relating to clinical governance are included in an expandable template. The areas listed are shown in Box 1.

Dissemination of the template

The associate medical director presented the template to the medical staff committee, the unit management board and the trust board. It was also presented and circulated on disk at the general managers' meeting. At all venues an opportunity was given for questions.

Initial concerns

A number of the managers felt that the report required a repetition of figures already produced, such as those relating to numbers of complaints, critical incidents and risk management issues. It was explained that their role would be to combine issues raised in all the areas within their directorate and look for any patterns that emerged, while taking an opportunity to develop training plans and personnel policies against emerging findings, if appropriate.

A document highlighting the key aims of the template was written to assist the managers. Each section was covered in turn, giving an outline of aspects to report on, as well as a list of key people to contact for further information.

The first reports

Of the nine clinical directorates, two reached a standard that was felt to achieve the primary objectives. A

Box 1. Areas listed in the clinical governance reporting template

- Clinical audit
- Clinical risk
- Critical incidents
- Complaints
- Health and safety (non-clinical risk)
- Appraisal
- Reports from the National Institute for Clinical Excellence (NICE)
- Clinical effectiveness
- Clinical records
- Research
- Personnel policy
- Training and development
- Patient involvement
- Other issues pertaining to clinical governance

meeting was held to discuss the content of the templates and allow the general managers an opportunity to talk about problems they may have encountered. Positive feedback was received even at this early stage. They felt the exercise had provided them with additional insight into directorate workings and information flows. Although template completion was felt to be rather hard work, they wanted to submit more, rather than less, information. Discussions also related to where information should be recorded; this could be unclear with, for example, an issue raised through critical incidents that could lead to the provision of, or changes in, training policy and new guidelines. It was agreed that it was not vital where the information was recorded – in fact, emphasis could differ between directorates.

The majority of issues likely to arise would be included in the nine reports. The only exception to this was felt to be the outpatient department, and a quarterly report was requested from the outpatient and health records manager. All other reports are fed through the directorate route. It was agreed that, should any diverse issues be identified, a separate letter should be written directly to the associate medical director.

Conclusion

Compilation of trust-wide clinical governance plans and reports is facilitated by the template reports.

Although in some cases great detail is not included in the report, even a brief mention of an initiative or development is sufficient to prompt the collection of additional information.

After four quarterly submissions, the reports are proving to be a useful tool for the general managers. There has been an increased awareness of clinical governance issues; for example, in some cases the general managers attend meetings to which they were not invited previously, or receive minutes of meetings that they did not receive before. As some of the data collection is delegated to senior nurses, multidisciplinary attendance at meetings has increased. One manager commented that the template had highlighted gaps in directorate office knowledge.

The template provides an extremely useful tool for the identification of clinical governance issues. Its structure ensures that information relating to directorates becomes centralised, which facilitates the development of linked and coordinated training and development plans.

The agendas of all staff vary enormously, with issues of vital importance to one staff group being virtually irrelevant to another. The reports received have opened up numerous opportunities for the dissemination of information on clinical governance. A considerable number of reports can be extracted from the templates; discussions are under way to prioritise these and set time scales for their development.