Why Quality Governance is still an area for improvement

A personal blog by:
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I have seen the governance of quality in the NHS evolve over my 10 plus years in the health sector, from clinical governance with a focus on complaints, incidents and audit, to CQC compliance against the five key lines of enquiry. Now, the focus is directed towards Quality Governance, under the three streams recommended by Lord Darzi – Patient Safety, Clinical Effectiveness and Patient Experience.

Even within the sphere of Quality Governance, individual aspects have evolved: from mortality and morbidity meetings we now also have Learning from Death reviews; from root cause analysis in serious incidents we now have Patient Safety Investigations and the Healthcare Safety Investigation Branch; from clinical audit we now also have quality improvement with kaizen plans and PDSA cycles.

Unfortunately, we have found this evolution has been partly driven from a number of investigations and public enquiries – from Bristol, to Morecambe Bay, to North Stafford and now Shrewsbury. To me, this raises one question – why do we continue to make the same mistakes when the lessons have been learnt time and again and published in print?

This was partly explored by the University of Manchester in their Responses to the Francis Report (2018) which focused on how Board governance had developed. However, how should management react?

Ultimately, I don't think it should be by prioritising one area of Quality Governance over another. This may seem controversial in an NHS that has been pushed to be more and more safety conscious, its latest manifestation is in the NHS Patient Safety Strategy[1]. Indeed, often the reaction of Trusts is to invest more in their Patient Safety teams – more investigators, more oversight of incidents and the learning from them.

Often we find these Patient Safety departments are reactionary and focused on dealing with problems as they arise, rather than being proactive in preventing incidents in the first place. We also find that they have colleagues across the corridor who do this very thing – in clinical effectiveness and patient experience teams.

For instance, when undertaking audits, the aim is to find gaps in practice against guidance and policy and make recommendations for improvement. When completing Learning from Death reviews, similarly the goal is to identify opportunities for improvements in practice in the care provided. From surveys, complaints and feedback - often these highlight areas of concern where action should can be taken. If these teams work together on common goals, focusing on areas of priority, then there will be both a proactive and reactive approach to improve quality.

WHO checklists are a prime example where audit, incident reporting and compliance with guidance, when working together, have delivered real progress in reducing surgical never events. If we build this same approach to other areas of practice, we can help make this both the safest and the highest quality healthcare system in the world.

1. https://improvement.nhs.uk/resources/patient-safety-strategy/