



HEALTH QUALITY & SAFETY
COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa



CLINICAL GOVERNANCE

GUIDANCE FOR HEALTH AND DISABILITY PROVIDERS

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Document information

Purpose

This guidance document sets out a high-level framework for clinical governance in health and disability services in New Zealand.

The conceptual basis for clinical governance has the consumer/patient at the centre surrounded by families/whānau, carers, health professionals, managers, governing boards, and professional and regulatory bodies, as well as central agencies such as the Health Quality & Safety Commission, the Accident Compensation Corporation and the Ministry of Health.

The defining values that underpin the above groups are consumer wellbeing and safety. Clinical governance provides a means for clinicians, managers and other staff to work together to improve and be held accountable for the quality and safety of the health and disability services they provide.

This guide can be implemented by all health and disability providers, regardless of their size or complexity, to provide accountability for continually improving their services and delivering a high standard of care. It is part of a suite of resources (shown below), which also support good clinical governance. Together, the resources are intended to provide the health sector with useful information, guidance and tools to help providers have in place sound governance and continuous quality improvement in the New Zealand health system.

Intended audience

This guide is aimed at all health and disability service providers in New Zealand and their staff. Other stakeholders, including consumers/patients and their families/whānau, may also find it of interest.

Associated resources

[*From knowledge to action: A framework for building quality and safety capability in the New Zealand health system*](#) (Health Quality & Safety Commission 2016b)



[*Governing for quality: A quality and safety guide for district health boards*](#) (Health Quality & Safety Commission 2016c)



[*Engaging with consumers: A guide for district health boards*](#) (Health Quality & Safety Commission 2015b)

**ENGAGING
WITH
CONSUMERS**

A guide for district health boards

[*Improving Together*](#) e-Learning modules (Ministry of Social Development, Ministry of Education, Ministry of Health and Health Quality & Safety Commission 2015)



Introduction to clinical governance

Introduction to clinical governance

Background and history of clinical governance

Clinical governance was first introduced in the United Kingdom (UK) in the late 1990s in response to major failures in the standard and delivery of patient care. The National Health Service (NHS) identified an imbalance between the priorities of managers and those of clinicians (fiscal, target-driven versus patient-centred, clinically focused) as central to these failures. Clinical governance was seen as a key vehicle for developing a shared commitment to high-quality care in everyday clinical practice.

Gabriel Scally and Liam Donaldson (1998), regional directors in the NHS, defined clinical governance as:

a system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, creating an environment in which excellence in clinical care will flourish.

Definitions of clinical governance have continued to evolve over time as the concept of clinical governance has been implemented in different health jurisdictions, and new initiatives and practices have emerged (Brennan and Flynn 2013). The drivers of clinical governance have also changed in response to developments in the culture of quality and safety and an increasing focus on patient-centred care (Ham et al 2012).

Use and application of the term 'clinical governance' has varied, in part because it is a composite mix of activities and relationships that link governance, management and practice that have been operationalised within different health systems (Flynn et al 2015).

Despite the variation there are some common approaches to clinical governance. These include:

- consumer/patient engagement and co-design
- open, transparent and learning culture
- prioritising quality improvement and patient safety
- clinical leadership for quality and safety
- an emphasis on partnerships and involvement of all staff
- effective multidisciplinary teamwork
- measuring clinical processes and outcomes
- use of data to identify variation
- effective management of clinical risks. (Flynn et al 2015)

The importance of consumer/patient involvement in improving the quality and safety of health care services is well recognised by New Zealand health professionals (Gauld and Horsburgh 2014a). New Zealand has yet to develop a formal definition for clinical governance. Variations of the Australian Council on Healthcare Standards' (2004) definition of clinical governance have been widely adopted with its strong emphasis on consumers being at the centre of continuous improvement of health care:

... the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents.

The Ministerial Task Group on Clinical Leadership's (2009) report *In Good Hands: Transforming Clinical Governance in New Zealand* highlighted the importance of fostering and developing clinical leadership at all levels in health care. The report described clinical leadership as a way of effecting change and enhancing quality, and as a means of ensuring effective partnerships between clinical staff and managers, particularly in district health boards (DHBs). Research shows that, since 2009, many DHBs have made a positive commitment to implementing clinical governance, but there is still a way to go. In a survey of 4000 New Zealand health professionals, 60 percent of respondents felt there was room to improve the quality of care provided by their health organisations (Gauld and Horsburgh 2015a).

A recent report by the New Zealand Treasury (2016) found that quality improvement programmes with effective clinical governance and leadership ‘can lead to quantifiable savings and/or efficiency gains... and achieve better outcomes for patients’. The report identified common success factors across the four DHBs studied as ‘alignment to strategic goals, executive and clinical leadership, culture and capability, measurement and results, and consumer engagement and patient experience’.

The principles and components of clinical governance described in this guide are not fundamentally new. But if they have been introduced in an ad hoc way or used in a fragmented manner within an organisational structure, clinical governance decisions can continue to be made in isolation from other key areas (Wolff and Taylor 2009). What is often missing is a framework that integrates and incorporates these decisions into an effective whole-of-system approach (Batalden and Davidoff 2007).

The focus of this guide is to provide a framework that will bring individual elements together and in doing so strengthen and sustain ongoing improvement across the five dimensions of quality defined by the Ministry of Health (2003): people-centred; access and equity; safety; effectiveness; and efficiency.

The Ministry of Health’s five key dimensions of quality rest on the foundations of the partnership, participation and protection principles of the Treaty of Waitangi.

- **People-centred** is the extent to which a service involves people, including consumers, their families and whānau, and is receptive and responsive to their needs and values. It includes participation, appropriateness, adherence to the Code of Health and Disability Services Consumers’ Rights 1996 and other consumer protections such as the Health Information Privacy Code 1994.
- **Access and equity** is the extent to which people are able to receive a service on the basis of need and likely benefit, irrespective of factors such as ethnicity, age, impairment or gender. It includes the physical environment, and the extent to which this is a barrier to accessing health and disability support services. Being able to physically access health and disability support service facilities can be a significant issue for people with disabilities.
- **Safety** is the extent to which harm is kept to a minimum.
- **Effectiveness** is the extent to which a service achieves an expected and measurable benefit.
- **Efficiency** is the extent to which a service gives the greatest possible benefit for the resources used.

What is clinical governance?

Clinical governance is an organisation-wide approach to the continuous quality improvement of clinical services. It is larger in scope than any single quality improvement initiative, committee or service. It involves the systematic joining-up of all patient safety and quality improvement initiatives within a health organisation. In practice, it requires clinicians to be engaged in both the clinical and management structure of their health organisation to contribute to the mission, goals and values of that organisation. It is also about managers engaging more with clinicians and enabling them to be involved.

One way to describe clinical governance is to look at it in terms of:

... the culture, the values, the processes and the procedures that must be put in place in order to achieve sustained quality of care in healthcare organisations. Clinical governance means moving towards a culture where safe, high quality patient-centred care is ensured by all those involved in the patient’s journey. (Department of Health and Children 2008)

Another way is to approach it from the role and responsibilities you hold and how these align with the aims and goals of your organisation. A hospital project manager in Ireland explained how clinical governance works in more personal terms:

‘People struggle with the phrase clinical governance, but really it’s about having a framework in place throughout the organisation, that supports you to be explicit about the standard of care delivered, about how you protect patients from harm, about how you listen to patients, and about how you plan and measure improvement.’ (Flynn et al 2015)

The outline of an effective clinical governance system described by Wolff and Taylor (2009) could apply equally across the health sector:

Doing the right thing, at the right time, by the right person, with the application of the best evidence to a patient's problem, in the way the patient wishes, by an appropriately trained and resourced individual or team, working within an organisation that is accountable for the actions of its staff, values its staff (appraises and develops them), minimises risk, and learns from good practice and indeed mistakes.

Clinical governance is achieved through a strategy that describes how the necessary components, activities and supporting structures come together and align with the organisation's overall quality strategy. Managers and clinicians are aware of their roles and responsibilities, and have the appropriate arrangements in place to manage and monitor the quality of the clinical services they deliver. Clinical governance supports consumer engagement and participation in decisions about the treatment, services and care they need and receive. When implemented well, clinical governance also gives assurance to the governing body of the organisation that the health and disability services they provide are safe and of a high quality (Braithwaite and Travaglia 2008).

Put simply, clinical governance is a collaborative venture between clinicians, managers and consumers that aims to 'create a culture where quality and safety is everybody's primary goal' (Flynn et al 2015).

What are the key principles of clinical governance?

The key principles for clinical governance to be effective are:

- consumer-/patient-centred care
- open and transparent culture
- all staff actively participate (and partner) in clinical governance
- continuous quality improvement focus.

To fully realise the building and sustaining of high-quality services focused on consumers/patients, their needs and their experience of care in an environment that fosters trust and openness requires an organisation-wide commitment. That commitment needs to engage all staff (Ministerial Task Group on Clinical Leadership 2009).

Roles and responsibilities – the part everyone plays in clinical governance

Clinical governance operates throughout organisations at different levels and in specific contexts. To be effective, clinical governance will be evident at all levels of the organisation so staff who are providing frontline patient care or working directly with consumers are aware of the part they play. Clinical governance needs to be as meaningful and accessible to frontline clinical staff as it is to managers and senior leaders. Senior organisational leaders and the governing body need to have a strategy to implement, embed and support clinical governance at all levels. There should be a systematic joining-up of all patient safety and quality improvement initiatives within a health organisation.

Using a DHB as an example, clinicians are responsible for critically reviewing the quality of care they provide, both individually and as part of their wider team; for introducing changes that will improve quality; and for raising issues that require a wider system response than they are able to provide.

Clinical directors and clinical service managers have joint responsibility for leading and overseeing the quality activities of clinical teams, and for planning and implementing appropriate service improvements.

Those funding services have a crucial role in articulating quality improvement from a community and whole-of-system view and in relating service design and development to improvements in population health status and outcomes.

The chief executive and leadership team provide organisation-wide leadership for quality improvement. The DHB board provides governance and oversight of all quality improvement activities (Ministry of Health 2013).

There should be strong consumer and clinical input at all levels of design, policy development, health service management, clinical research, education and training programmes and guideline development (Health Quality & Safety Commission 2015b).

In smaller organisations the same responsibilities and accountabilities apply, but the consumer/patient group may be smaller and the services delivered generally less complex. The commitment to consumer/patient first, partnership and continuous improvement is still central. The emphasis is not on the size or specific purpose of the organisation; it is on shared responsibility and accountability for the culture of engagement in patient safety and continuous quality improvement. 🌱

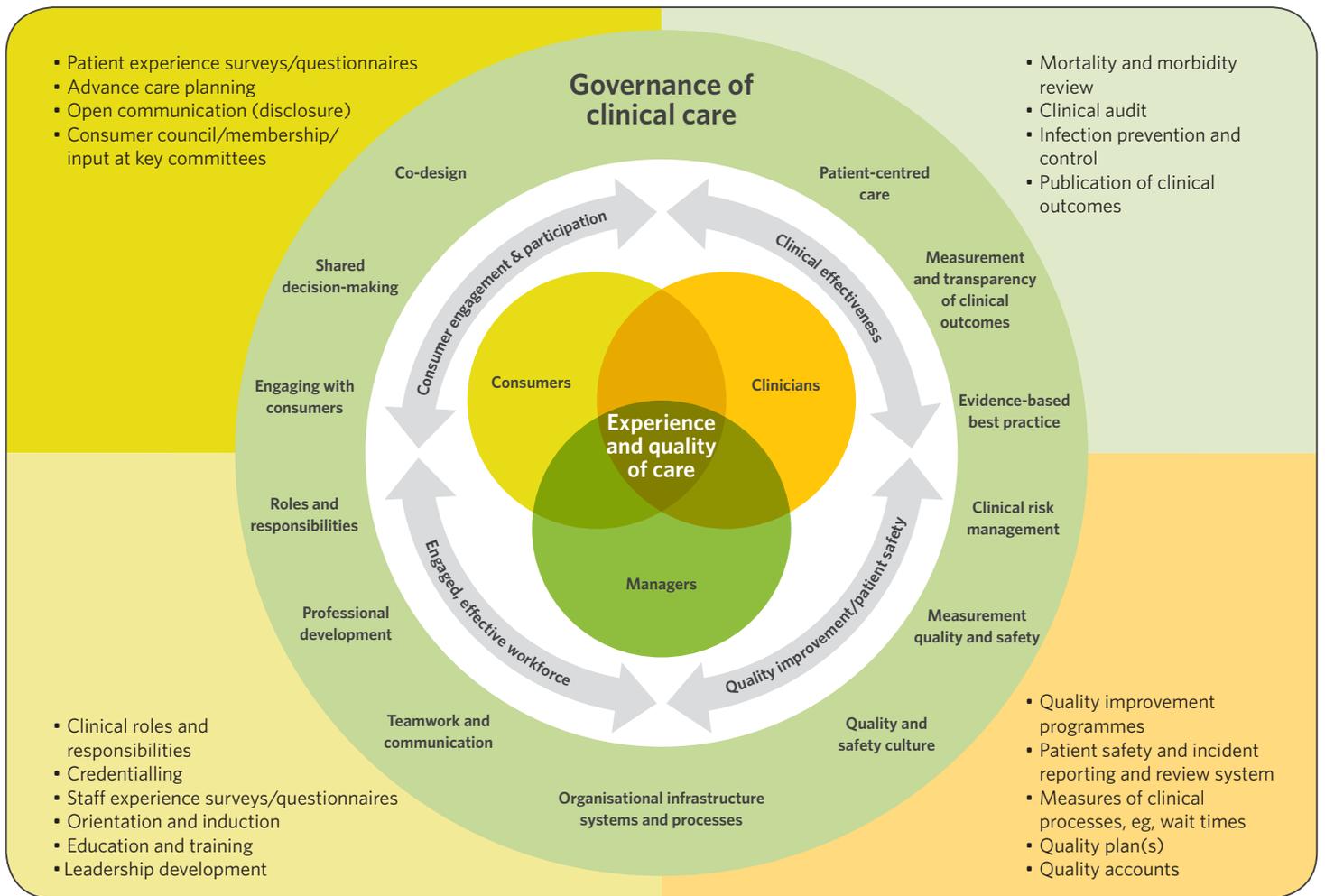
A framework for clinical governance

A framework for clinical governance

An effective clinical governance framework has four components or ‘building blocks’ (Figure 1). These provide a structure for strategies to improve and enhance the quality of care, and include:

- consumer engagement and participation: making decisions about their own care and taking part in the design, delivery and evaluation of the services they use
- clinical effectiveness: the application of knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients
- a commitment to working on quality improvement and patient safety
- an engaged, effective workforce.

Figure 1: The key components of the clinical governance framework



The four framework components

In the following section, we describe, from the perspective of providers, how the framework for clinical governance can be brought to life within their organisations.

CONSUMER ENGAGEMENT AND PARTICIPATION

Enabling consumers/patients and their families/whānau as members of the health team

Strategic approach

- The concepts of consumer/patient engagement and consumer/patient partnership across the spectrum of health care are a key strategy for improving health outcomes.
- We as health providers encourage and enable consumers/patients and their families/whānau to engage in ways that empower them to achieve their desired outcomes to the degree they are able or wish to.

Capabilities and structure

- We have in place systems to support consumer-/patient-centred care, health literacy and cultural safety.
- All our clinicians practise consumer-/patient-centred care.
- Consumers/patients and their families/whānau are involved at all levels in improving the design and delivery of care.
- All our staff understand and act upon the rights of consumers/patients and their families/whānau to receive information.

Partnership with patients

We provide:

- active support for patients to be involved in shared decision-making about their care and treatment, and to engage in care service delivery and design (Health and Disability Commissioner 1996)
- encouragement and support for consumers/patients and their families/whānau to form partnerships with health providers (Health Quality & Safety Commission 2016b).

Patient experience surveys/questionnaires

We:

- prioritise patient experience and feedback as key indicators of health care quality
- use a range of measures to determine how well health services are working for consumers/patients and their families/whānau (Health Quality & Safety Commission 2016d).

Advance care planning

We:

- provide active support for consumers/patients and their families/whānau to be involved in their own care planning
- listen to the values, preferences and goals of care of consumers/patients and their families/whānau when discussing treatment options, plans for the future and end-of-life care (National Advance Care Planning Cooperative 2013).

Open communication

We integrate and support other clinical governance processes, including clinical incident reporting procedures and systems review, complaints management, privacy and confidentiality procedures (McAuliffe 2014).

Health literacy

We recognise health literacy as fundamental for consumers/patients to be able to obtain, understand and use basic health information; to navigate health services and make appropriate health decisions; and for clinicians to plan and provide safe care (Health Quality & Safety Commission 2015d).

Consumer/patient participation	Consumer/patient participation in consumer councils, key committees and advisory groups enables them to contribute to discussions on improved quality and safety, and to have their values incorporated in decision-making (Carman et al 2013).
Shared decision-making	Consumers'/patients' values, preferences and experience, as well as the best clinical evidence available, are integral to the shared decision-making process (Health and Disability Commissioner 1996, 2009).
Co-design	We implement co-design as an evidence-based approach that 'uses patient and staff experience to design better health care services' so health professionals understand experiences from the perspective of patients, carers and staff (Health Quality & Safety Commission 2016a).
Patient stories	We listen to, collate and share consumer/patient stories and narratives to build a picture of what it is like to experience care, and to highlight where sometimes simple improvements would make a difference to the patient experience (Health Quality & Safety Commission 2015b).

Questions to consider

Consumers/patients should be at the centre of any clinical governance system. Their health outcomes and experience of care should be transparent to all and used to continuously improve services.

- Is there clear, open and respectful communication between our organisation and consumers?
 - Does the board engage with consumers, and proactively seek their feedback on their experience of care?
 - Do services learn from that feedback?
 - Do clinicians participate and partner with consumers/patients in designing quality systems and processes of care?
 - Do consumers/patients participate in the planning and evaluation of services for improvement?
- Do consumers/patients participate in key committees?

CLINICAL EFFECTIVENESS

'[T]he application of best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients' (NHS Executive 1996)

Strategic approach

- We use evidence-based, effective interventions and treatments based on the principles of good practice.
- Evidence and data drive improvement and innovation, minimising harm, waste and variation.
- We include consumers/patients in the process of determining which outcome measures are reported and how the information is presented.

Capabilities and structure

- We have systems in place for giving all health care workers access to up-to-date evidence and data.
- We make available appropriate education and training, resources and information to support best practice.
- We have in place systems to allow the multidisciplinary team to review their own practice, so it is consistent with current knowledge and evidence, and the results are used for learning and to improve care and minimise harm for patients.
- Transparency and openness are core values of our organisation.
- We have systems in place for sharing improvements.

Measurement and transparency of clinical outcomes

We:

- include patients/consumers in the process of determining which outcome measures are reported and how the information is presented, for example, through co-design
- use accurate, valid data to provide meaningful information on the outcomes measured
- support transparency and openness by the public reporting of judiciously chosen, adequately risk-adjusted measures at the team, unit or organisational level
- present results in different formats and media so as not to increase inequity through failure to address differences in health literacy and access to information
- use findings to contribute to improvement in quality of care services and help with planning and decision-making (Health Quality & Safety Commission 2016e)
- share improvements openly.

Evidence-based best practice

Clinicians embed and use evidence-based guidelines in the care delivery system to improve decision-making support and provide safe, quality services (Sackett et al 1996).

Mortality and morbidity reviews

We:

- hold regular multidisciplinary meetings that include all clinicians, technicians and managers involved in patients' care
- discuss adverse outcomes collaboratively, focusing on potential systems-based improvements in patient care and safety (Deis et al (nd); Higginson et al 2012)
- focus reviews on identifying issues related to the process or systems of care that led to the death or incident and not on the individuals who provided care (New South Wales Health Department 2001)
- support quality improvement, professional learning and open communication through our reviews
- follow up action plans to check the actions are implemented.

Clinical audit	<p>We use clinical audit to measure the quality of care and services against agreed standards and make improvements where necessary.</p> <p>Clinical audit is integral to the quality improvement approach to improving clinical care and services (National Institute for Clinical Excellence 2002), and we follow up unexpected results with action plans and clear accountability.</p>
Infection prevention and control	<p>Infection prevention and control in health services is integral to quality and safety improvement and clinical risk management (Standards Council 2008).</p> <p>We have clear leadership of related activities.</p>
Open publication of clinical outcomes	<p>We publish and use clinical outcomes to give consumers/patients balanced and objective information to help them understand issues, alternatives, opportunities and/or solutions (Health Quality & Safety Commission 2015b).</p>

Questions to consider

Effective clinical governance means everyone understands their roles in and responsibilities for quality and safety. They take an active part in improving both individual and team clinical outcomes by reducing harm, waste and variation.

- Do all staff understand the principles of clinical governance and how they apply to their individual and team roles?
- Do staff accept responsibility for quality and safety, and know who they are accountable to and their level of authority?
- Do staff consistently demonstrate a commitment to the principles of clinical governance in their decision-making?
- Are quality and safety measured for the purpose of ongoing improvement?
- Do we have an environment where clinical excellence flourishes?
- Are quality and safety measures included in staff performance appraisal systems?
- Are staff encouraged to participate in multidisciplinary teams, and are effective multidisciplinary clinical audit processes in place?
- Do individual clinicians take responsibility for:
 - being competent in all aspects of their work
 - recognising and working within the limits of their competence
 - reviewing the standard of care they provide
 - participating in external reviews and audits
 - taking action to resolve issues when they are not satisfied with the standard of care or service provided?

QUALITY IMPROVEMENT AND PATIENT SAFETY
Increasing the capabilities of everyone participating in the health workforce in quality and safety improvement appropriate to their role and sphere of work

Strategic approach

- Patient safety and quality of care are our top priorities.
- Increasing organisational capability and capacity in quality improvement and patient safety is essential to having safer and better quality care.
- We identify and manage clinical risks within a just culture.

Capabilities and structure

- We have a coherent and effective quality and safety framework.
- The health and disability sector has in place effective governance and leadership, both clinical and managerial, across all levels to support improved quality and safety.
- All health care workers have a foundation-level understanding of quality improvement and patient safety knowledge, methods and the actions they need to take to achieve better quality and safety.
- Appropriate tools, methods and techniques are used to improve the quality and safety of care.
- Expertise in quality and safety is available to influence strategy and policy, and translate organisational goals into actions at the front line of care.
- We have in place an appropriate infrastructure to support the identification, recognition and review of patient safety incidents and/or adverse events and near misses.

Quality and safety culture	Our organisational focus is on prioritising and enabling safe, high-quality health care, consumer/patient engagement, teamwork, openness/transparency and accountability (Lamb et al 2003).
Data for monitoring clinical care	Data is appropriate to the level and type of service provided. We collate, analyse and report regularly to all levels of the organisation, including consumers/patients.
Clinical risk management	We have in place clinical and operational risk management systems to improve the quality and safety of services by identifying the circumstances and opportunities that put patients at risk of harm, and then acting to prevent or control those risks.
Patient safety and incident reporting systems	<ul style="list-style-type: none"> • Our staff use appropriate safety practices to manage risk and increase the reliability and safety of care. • Our organisational culture supports open communication and a systems approach to learning from incidents, adverse events and near misses. • We respond proactively to known clinical risks (Victorian Government Department of Human Services 2009).
Measures of clinical processes	<p>We:</p> <ul style="list-style-type: none"> • use valid and reliable measures to evaluate clinical processes and inform improvement and change • support best and innovative practice changes • measure and act upon consumer/patient experience of care (Health Quality & Safety Commission 2016b).
Quality accounts (DHBs)	We publish quality accounts annually to tell our DHB's stories, including our commitment to quality improvement and how the public and local communities play a part in making health services better and more responsive (Health Quality & Safety Commission 2016a).

Quality plans	<p>Our key objectives include the development of a sustainable culture of quality and safety for the organisation.</p> <p>Our plans have a clear and evident alignment to our strategic plan, which articulates the quality and safety vision for our organisation.</p> <p>Our plans are consumer-/patient-centred, are clear and easy to understand and interpret, have measurable goals, and support sustainable culture change (Health Quality & Safety Commission 2016b).</p>
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Questions to consider

Organisations need to build an accurate, comprehensive picture about quality and safety so they can identify and act on quality of care issues.

- Does our organisation collect the data it needs to identify and monitor quality and safety?
- Are systems in place for staff to raise concerns safely and confidently about quality and patient safety?
- Are clinical risks integrated into our organisational risk management framework?
- Is there regular review, monitoring and reporting on significant clinical risks?

ENGAGED, EFFECTIVE WORKFORCE
An engaged, effective workforce that works in partnership with consumers/patients and their families/whānau and actively participates in an ongoing process of self and peer review

Strategic approach

- Everyone in our organisation clearly communicates and role-models expectations and standards of performance.
- We foster and support multidisciplinary teamwork.
- We plan and provide professional development for a health workforce with appropriate knowledge and skills.
- Education, training, development and mentoring support the workforce.
- We encourage proven innovative practice (Victorian Government Department of Human Services 2009).

Capabilities and structure

- We provide support so clinical staff and managers have the skills, knowledge, training and organisational resources to perform the tasks required of them, and they understand the concepts of quality and safety and continuous improvement.
- We include contracted and locum staff in these processes.

<p>Orientation and induction</p>	<p>We:</p> <ul style="list-style-type: none"> • clearly communicate to new staff our organisational values and vision for quality and safety • orientate new staff to where their role fits in the context of the wider system of care and services provided. They are aware of the core organisational values of consumer-/patient-centred care, including health literacy and cultural safety • identify at orientation the key organisational arrangements, policies personnel and resources available • highlight effective communication, mutual respect and shared values as basic competencies to help health care teams achieve the best outcomes for consumers/patients • identify clinical and operational risk awareness and reporting as central to patient safety and quality improvement (Health Quality & Safety Commission 2016b).
<p>Education and training</p>	<ul style="list-style-type: none"> • Staff engage in ongoing professional development and regulatory body requirements to maintain their skills and competence to perform their roles and responsibilities. • Staff are knowledgeable in quality improvement and patient safety concepts and theories, and have the skills to build quality improvement and patient safety capability and expertise. We have in place systems for sharing and learning from failures and successes. These systems support the application of appropriate safety practices to manage risk and increase the reliability of safe care (Health Quality & Safety Commission 2016b).
<p>Roles and responsibilities</p>	<p>We:</p> <ul style="list-style-type: none"> • clearly define roles and responsibilities • give staff information, resources, training and development so they can perform their roles and meet their responsibilities • clearly articulate team members’ roles, strengths and responsibilities so they are understood • mentor and empower staff to apply the principles of consumer-/patient-centred care in their everyday practice • support capability in quality and safety so staff can meet their responsibilities as part of the team/organisation.

Professional development	<p>We:</p> <ul style="list-style-type: none"> ▪ give staff access to appropriate continuing professional development and professional education so their practice is consistent with current knowledge ▪ support staff to participate in quality improvement and patient safety projects (Health Quality & Safety Commission 2016b).
Teamwork and communication	<p>We:</p> <ul style="list-style-type: none"> ▪ foster team culture to support quality and safety ▪ clearly articulate teams' roles, responsibilities and purpose so they are understood ▪ allocate time to team-building to help teams function better ▪ communicate in writing and verbally using clear, respectful and logical language ▪ promote active listening in day-to-day communication ▪ give, receive and act on constructive feedback ▪ model effective strategies for conflict management (Health Quality & Safety Commission 2016b).
Leadership development	<p>Staff demonstrate leadership appropriate to their role. We provide training and support so staff know when and how to step up and take action for quality and safety.</p> <p>We recognise and support leadership development as part of effective clinical governance.</p> <p>We identify potential leaders, offer them mentoring and give them opportunities to develop quality and safety knowledge and skills.</p>
Individual and service credentialling	<p>All health practitioners have the appropriate skills and knowledge required to fulfil their roles and responsibilities within the organisation. Our facilities and resources can support their range of practice.</p> <p>We have in place a formal process focused on patient safety and the protection of health consumers, support for clinical improvement activities, improvement in risk management, and promotion of professional practice development (New South Wales Health Department 2001).</p>
Clinical supervision	<p>We:</p> <ul style="list-style-type: none"> ▪ have systems and processes in place to monitor and maintain the quality and safety of the professional services offered to consumers/patients by staff in training ▪ support staff in training and other clinicians in supervision to apply their professional knowledge to their current and future work with consumers/patients, both as individuals and as part of their multidisciplinary team. Their professional development occurs in a safe and supportive environment (New South Wales Health Department 2001).

Questions to consider

Clinicians are at the centre of an organisation's clinical governance arrangements. Their leadership and commitment are crucial.

- Are clinicians represented at board and executive leadership level?
- Are standards of clinical care clearly articulated and communicated?
- Are roles and responsibilities clearly articulated and understood, and are there clear lines of responsibility across our organisation?
- Are induction and orientation of staff effective?
- Is there ongoing supervision for those in training?
- Are clinicians engaged and involved to improve clinical care delivery?
- Is there effective clinical participation on quality and safety committees?
- Are sufficient time and resources made available to support clinician involvement in clinical governance?
- Are clinicians encouraged to partner on all quality and safety issues?
- Do we have in place robust credentialling processes that clinicians participate in as part of their employment?
- Do we identify and develop potential clinical leaders?

In summary

Clinical governance is an organisation-wide approach to the continuous quality improvement of clinical services. It is larger in scope than any single quality improvement initiative, committee or service. It involves the systematic joining-up of all patient safety and quality improvement initiatives within a health organisation.

Questions to consider

The key principles and components of clinical governance described in the framework can help organisations build an effective clinical governance strategy.

- Is clinical governance embedded and enabled within the overall governance of your organisation at all levels?
- Are quality and safety included in your strategic vision and clearly articulated to all staff?
- Is there evidence of a culture of trust and openness in your organisation, and do you champion, measure and improve the quality and safety culture?
- Does everyone take responsibility for quality and safety?
- Are there strong partnerships between consumers/patients, families/whānau, managers, clinicians and other staff?
- Is your organisation transparent about the clinical outcomes it achieves for the communities it serves?
- Are your clinical governance processes and systems open to public scrutiny?
- Do governance/board members receive comprehensive, up-to-date information and data about the quality and experience of patient care? 🌱

Glossary of key concepts and definitions

Capability	The extent to which individuals can adapt to change, generate new knowledge and continue to improve their performance (Fraser and Greenhalgh 2001).
Clinical audit	'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' (National Institute for Clinical Excellence 2002).
Clinical risk management	Clinical risk management is concerned with improving the quality and safety of health care services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risks (Reason 2001).
Clinician	Medical practitioner, nurse, midwife or allied health professional.
Co-design	Brings consumers/patients, families/whānau and staff together to share the role of improving care through the re-design of services. It is a proven methodology, which provides tools for effectively increasing the engagement of consumers in decision-making and design of health and disability services.
Consumer	A person who has accessed or is currently using a health or disability service or is likely to do so in the future (Health Quality & Safety Commission 2015b).
Consumer engagement	<p>Consumers/patients, families/whānau, their representatives and health professionals working in active partnership at various levels across the health care system – direct care, organisational design and governance, and policy-making – to improve health and health care (Carman et al 2013).</p> <p>'A process whereby consumers of health and disability services are encouraged and empowered to actively participate in decisions about the treatment, services and care they need and receive. It is most successful when consumers and clinicians demonstrate mutual respect, active listening and have confidence to participate in full and frank conversation. Systems that support consumer engagement actively seek input from consumers and staff at all levels of an organisation' (Health Quality & Safety Commission 2015a).</p>
Culture	A system of shared values, assumptions, beliefs, behaviours and norms that represent the expectations and image of a particular people, organisation or system (adapted from Wikipedia).
Evidence-based medicine	The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients (Sackett et al 1996).
Governance	Encompasses the systems, processes and relationships through which an entity is directed or controlled (Institute of Directors (nd)).
Leadership	In health, leadership has been described as 'a mechanism for effecting change and enhancing quality... it requires a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients' (Department of Health 2008).

Open communication	The timely and transparent approach to communicating with, engaging with, and supporting consumers/patients and their families/whānau when things go wrong (Health Quality & Safety Commission 2012).
Openness and transparency	Being honest, easy to understand and completely free from concealment (www.merriam-webster.com).
Patient safety	The management of risk over time in order to maximise benefit and minimise harm to patients in the health care system (Vincent and Amalberti 2016).
Risk	In the context of risk management, risk is defined as the chance of something happening that will have an impact upon objectives. Risk may have a positive or negative effect.

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