Clinical Lead Survival Guide – Clinical Governance

As a clinical lead for ophthalmology you will need to ensure the department undertakes appropriate clinical governance activities. This is a short guide to help you.

Step 1 Understand the buzz words and the basic concepts

It's important to know and understand a few of the words and concepts to ensure you can organise things sensibly and speak to managers with some semblance of knowing what you are doing. *Quality and safety* in care are what you are trying to achieve, *clinical governance* (CG) is simply the term used for the framework and tools you use to achieve that quality and safety.

If you want to keep it simple, always come back to the basics of what you are trying to do:

- Quality assurance: you want to ensure the department's quality of care is of an acceptable minimum standard. Standards of care below which things really ought not to slip are sometimes called *fundamental standards*.
- Quality improvement: you want to identify where care could be better and do something to improve it
- Safety: you want to avoid or minimise patients suffering healthcare-related harm.

If you are struggling with the terminology or the methodology, just remind yourself of these three things.

The classification:

The most widely accepted classification of clinical governance, and the easiest to remember, is from Darzi and divides CG into 3 domains:

Clinical effectiveness:

- Deliver good evidence based care
- Obtain good outcomes (results for patients)

Patient safety:

- Spot risks and prevent harm before it happens
- Minimise harm after an adverse event

Patient experience:

- Treat patients like humans, engage them in their treatment, involve them in service design.

The more recent, but less easy to remember, classification is from the CQC – their key lines of enquiry or KLOEs (i.e. the headings under which they judge you) which are:

- Safe
- Effective
- Caring
- Responsive
- Well led

Caring and responsive add up to patient experience, safe and effective are the same as Darzi, and well led is self-explanatory. Some hospitals will prefer you to use the Care Quality Commission (CQC one).

Step 2 Getting started – set up a structure

Leadership: Appoint a CG lead (often but not necessarily a consultant) who is going to do most of the work, and has a bit of an interest in it. If it's a large department, it's often useful to have a doctor and a nurse or AHP working together e.g. as lead and deputy.

The CG lead must be joined up to organisational CG leads/committees i.e. they must get to know the trust's CG or risk manager and attend the appropriate level trust CG committee. The CG lead needs to read up a bit online about CG and quality and, very early on, stimulate interest and run an educational session for the multidisciplinary staff on the basics of CG and why it matters.

CG Meetings: The department needs to hold regular multidisciplinary CG meetings with agendas and minutes and actions with named leads. The actions need to be chased and status reported on at the next CG meeting. Most hospitals hold these anything from once a month to three or four times a year. Any less than that and nothing gets done. Organise the agenda and meeting based on the three CG areas or, if the trust makes you, the CQC KLOEs.

Do the work: The clinical lead and CG lead need to work through the three key CG areas using the *tools of the trade* as described below so there is a plan, and this needs regular thought and updates.

Measure regularly: Understand the data; compare with internal and external standards, compare internally looking for outliers.

Act: Tackle problem areas and people identified either from the data or where everyone is aware things are poor. Take ownership of problems and find solutions within the department. Clinicians and departmental staff have the best chance of, and most motivation for, solving their problems.

Communicate the results of data, the issues, the good points and the learning or actions taken.

Step 3 Measurement. How do you know the basic quality of the department and what do you measure?

Every eye department ought to have a regular quality report or scorecard to demonstrate how it is doing against key measures and standards. Ideally this is viewed monthly, although some measures might in fact only get measured once per year e.g. some clinical audits. A scorecard for quality developed through Moorfields Vanguard Programme work is available to downloadable via http://www.networkedcaretoolkit.org.uk/categories/purpose/standardisation/measuring-single-specialty-services/. You might not want to measure every single aspect but it provides a good source from which to pick useful ideas.

Every department ought to consider measuring the following at minimum:

Clinical audits
Cataract clinical audit: Measure rates of PCR, % BCVA ≥6/12, % refractive results with +/- 1D of target, rate of endophthalmitis at least once per year. Also submit to the NOD national audit. Big departments ought to consider doing PCR and endophthalmitis rates more often.

Other clinical audits: at least every one to two years:

- AMD: 15 letter VA gain and loss at one year, adherence to recommended injection timings especially when commencing treatment.
- Intravitreal injections: endophthalmitis rate.
- Glaucoma: NICE guideline adherence and trabeculectomy/tube failure/success/complication rates at one year postop.
- VR: Primary RD reattachment rate & complications; macular hole closure rate & complications
- Corneal grafts: rates of failure and rejection at 1 year postop, rates of graft detachment if endothelial. Ideally use UKBT national audit results.
- Strabismus: rate of serious complications vs BOSU rate, reoperation rates at one year post, results in terms of angle and satisfaction.
- Paediatrics: Amblyopia therapy results, ROP screening guideline adherence, adherence to orthoptic protocols.

College Quality Standards
Measure every 1-3 years for all the subspecialties and patient groups as relevant. Consider using the electronic tool for this on the College website which gives you a confidential print out of how you did for all (except children, learning disabilities and dementia).

- Adnexal
- External disease/cornea
- VR
- MR
- DR
- Neuro-ophthalmology
- Glaucoma
- Cataract
- A&E
- Children and young people
- Learning disabilities
- Sight loss and dementia

Other
Also need monthly measures of your Incident rates, number or rates of complaints, numbers of serious incidents, FFT (national friend and family test feedback survey) response rate and score, timeliness of follow ups in key areas (MR, glaucoma), % WHO checklist compliance.

Step 4 Working on clinical effectiveness

Delivering good evidence based care: this involves having a good structure and good processes.

Structure means your set up, that is:

- staff and services
- physical environment
- equipment

What tools can you use to ensure good structure?

Check your patients can access comprehensive services:

- being clear what you offer during the day for general vs subspecialty services. If not in house, is it clear and agreed how patients can access subspecialty care?
- out of hours: do you have proper out of hours services for general and for subspecialty care? Is there a clear pathway if you cannot offer it?

Staffing:

- Do you have qualified, registered & trained staff for purpose?
- Do you have the right number of staff?
- Are staff properly supervised including juniors and AHPs?
- Mandatory updates % compliance
- CPD and teaching are offered and properly taken up
- Appraisal & assessment; PDP; revalidation all done properly and up to date
- Poor performance is managed
- Extended roles and virtuals: AHPs and technicians must have recorded competencies and protocols
- Staff surveys

Equipment & environment

- Assess your environment and space, is it clear, big enough, suitable etc?
- Ensure and you can evidence appropriate:
- Maintenance and servicing
- Training
- Calibration
- Cleaning
- Laser safety:
    - Officer
    - Rules
    - Environment

Process

What you do, making sure you do the right thing (e.g. tests, drugs, treatment) to right patient/disease at right time for right reason

What tools do you use for good process? You need to have local written evidence based guidelines, policies and protocols, based on guidance from national recognised bodies. Key ones to consider are:

- NICE & RCOphth – AMD, RVO, DR, glaucoma, cataract, ROP
- RCOphth – service guidance: theatres, outpatient, A&E, virtuals, devices etc
- BIOS & orthoptic – amblyopia, testing
- Local interest or issues: you MUST have an IOL selection protocol to avoid never events
- PGDs for drops, extended role & virtual protocols

You need to use clinical audit to regularly assess adherence to these protocols and guidelines.

Obtain good outcomes (results for patients)
How do you know? You need to do clinical audit to measure your outcomes in key areas (see step 3) regularly and in other areas as necessary depending upon importance or concerns.

Step 5 Working on patient safety (ask risk management)

This is to:

- Prevent or reduce frequency/severity of adverse events before they occur
- Minimise harm following an adverse event.

What are the tools for patient safety? There are lots of them to choose from, but the key ones in any eye department to reduce risk are the following:

- Manage incidents, Never Events and SI (serious incidents) properly
- Know your new patient delays
- Know your follow up patient delays
- Clinicians should actively deal with cancellations, DNAs considering clinical situation, etc not leave it to non- clinical clerks
- Use the ophthalmic WHO checklist for operations and procedures
- Have an IOL selection protocol and follow it
- Do your ophthalmic risk assessments regularly

Important things to remember about incidents:

- Use your incident recording system: over-report rather than under-report
- Each incident needs a risk rating (harm level x likelihood of recurring)
- Learn don't blame. Learn and take preventative action so it doesn't happen again.
- Analyse your incidents looking at frequency, trends and themes
- Analysis is done nationally via the National Reporting and Learning System (NRLS), MHRA for national themes from rare things
- Follow Being Open & Duty of Candour if significant harm, it's a legal requirement. Tell the patient what's happened, what it means and apologise. Write it in the notes. Confirm it via a letter to the patient.
- For most incidents, it's about local ownership and an informal process to learn and act. That means you and your manager not the trust needs to investigate and sort it out and prevent it recurring.

- Never events & SIs are externally declared and undergo formal investigation using root cause analysis/report lead by the trust risk manager with you.

Step 6 Managing patient experience

Important tools for good patient experience are:

- Explain the diagnosis, what it means, the treatment, the prognosis every single time and ensure all the doctors know to do so.
- Consent properly and before the day. Use procedure specific consent forms and leaflets but make sure you individualise the discussion and record it in the notes
- Patient information: have good leaflets on all the key things (cataract, glaucoma, AMD, diabetic retinopathy, squint refractive error, amblyopia etc)
- Patient centred practice (dignity, privacy, communication issues, accessible pleasant and safe environment).
- Needs of minorities & the vulnerable. Ensure things are suitable for visually impaired patients that is big font leaflets and letters, visually impaired (VI) suitable signage and suitable environment, VI training for staff
- Have an ECLO. Check what % eligible are CVI registered.
- Get patient feedback: Surveys/questionnaires, friends and family test (FFT) and act on it.
- PALs help with informal concerns
- Complaints: manage them and learn from them to change things
- Walkarounds: do mock CQC walkarounds, ideally with staff, patients and Board members. Take a questionnaire. Write a little report and get things changed. THIS IS CRUCIAL FOR MULTISITE EYE DEPTS OR NETWORKS OF CARE
- Have patient representatives/advocates, user groups, try to design services with patients where possible

Step 7

Top tips for managing services on multiple sites:

If multiple sites or a network:

- All must adhere to same governance rules
- Crucial to have written policies and guidelines which all sites use so you are doing the same thing
- Mock CQC walkarounds
- Peer to peer learning across sites, central teams visit and train at all sites
- Staff need to some extent to move across sites so not isolated
- Data measures and CG actions done across whole network AND per site with comparison between sites
- Need staff you can trust running the sites
- Record competencies for non-medical staff
- Have tight SLAs and contracts for everything
- Excellent remote connections and systems for sharing data and remote meetings
- Have very clear structures, reporting and accountability

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Appendix 1: Important incidents in ophthalmology

- Delay in referral or clinic appt leading to visual loss
- Missing or incomplete notes
- Delayed diagnosis intraocular FB
- Delayed diagnosis intracranial tumour
- Delayed diagnosis retinal tear
- Failure to screen ROP leading to visual loss
- Lost to follow-up especially vulnerable patients
- Drugs: Wrong drug administered; prescribed drugs not instilled; wrong prescription; serious drug reaction
- Unexpected perioperative death
- Operation on the wrong eye, or wrong patient
- Wrong operation on correct eye, includes wrong implant
- Penetration or perforation of globe during periocular injections
- Expulsive haemorrhage
- Endophthalmitis within 6 weeks of eye surgery
- Patient collapse requiring resuscitation during eye surgery
- Unplanned returns to theatre or readmissions
- Surgical device failure, opaque/faulty lens