

Q5: Do you agree with the scope of the proposed clinical governance standards?

The GMC recently updated our [Handbook on effective clinical governance to support revalidation](#) to capture the issues that we and the stakeholders we collaborated with (including HIS) thought were important to reflect. We are grateful for HIS' input as part of this process.

We are pleased to see inclusion of independent healthcare providers within the scope of providers responsible for meeting the standards. We acknowledge the challenges that can exist in communication and ownership of managing concerns that can exist where healthcare professionals provide services at NHS and independent providers. This is an area we tried to strengthen in our guidance, so we support the clarification of the role of independent providers in clinical governance.

Q6: Do you agree with the definition of 'clinical' used in the proposed clinical governance standards?

In essence, the GMC views clinical governance as a fundamental framework for ensuring safe, effective, and high-quality patient care within medical organisations. It's about more than just procedures; it's about fostering a culture where quality and safety are at the heart of everything the organisation does. The HIS definition of 'clinical' used in the context of the proposed clinical governance standards aligns with our approach.

That being said, we would suggest HIS considers whether the proposed definition is sufficiently broad to encompass both registered and unregistered colleagues, as we would expect all colleagues (registered or unregistered) to be involved in the delivery of clinical services to abide by clinical governance standards.

Q7: Do you agree with the definition of the domains used in the proposed clinical governance standards?

We broadly agree with this, but have some additional thoughts related to the domains, specifically:

- Staffing and staff management – We wonder if it would be useful to indicate, at a high level, staffing ratio/ safe working standards.
- Clinical audit and quality improvement – We consider a brief reference to the Scottish government's Quality Strategy for Health and Social Care could be used here to be more explicit to strategically align the work.
- Clinical effectiveness – It could be helpful to include reference to NICE compliance, HIS quality framework compliance.

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- Risk management – We suggest this could make reference to speaking up and its importance in patient safety, linking to staffing and staff management, clinical effectiveness and education & training.
 - Education and training – We consider it could be useful to explicitly identify the link between education & training, and staffing and staff management.

Q8: Please detail any gaps or omissions you feel may be in the proposed clinical governance standards

The revised scoping document currently contains high-level content. If HIS wishes to include detail and expand the scope they may wish to consider taking into account the following points:

- Whether ‘learn from’ could be added to the domain of – Clinical audit and quality improvement: *‘The functions, roles, responsibilities and structures in place to monitor, evaluate, assess and improve quality and safety of clinical care’*. This would be to reflect how important it is that organisations take account of learnings and best practice, to help ensure effective and robust clinical governance processes to protect patient safety. This includes sharing outcomes and learning arising from clinical governance processes with healthcare professionals and patients.
- Whether one of the domains (e.g. ‘risk management and safety’ or ‘data and information’), should cover early identification of concerns, information sharing. Information sharing is vital in ensuring good clinical governance, particularly where healthcare professionals are working in multiple organisations, or move from one organisation to another.
- We note the inclusion of *‘values, behaviours, purpose, goals and priorities of an organisation’*, under the domain of ‘Staffing and staff management’, and agree these are really crucial areas to have standards around. We note that this domain focuses on *‘the accountability and transparency of senior managers and executive leaders’*, and wondered whether this could be strengthened to acknowledge the importance of leaders taking active steps to create positive workplace cultures and environments that make everyone feel safe to speak up, and supported when they do.
- In terms of the ‘Service user and patient involvement’ domain: we think an important feature of maintaining this is “closing the loop”, e.g. providing feedback on the outcomes when concerns have been raised. Learning from issues in England it may also be useful to incorporate the ‘family voice’ as part of this domain.
- We also suggest that it might be helpful to reference ED&I, inclusivity and fairness considerations.
- The scoping report also makes no reference to professional development. It could be inferred by some of the reference under education and clinical audit & QI, but we feel there is an opportunity to say it explicitly. In particular the use of data to support professional development would be an important bridge to improving patient care overall.

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- Explicit reference to performance management and the importance of this in clinical governance would also be relevant to consider adding.
 - We also consider that the education and workforce standards may benefit from emphasising more that medical education and supporting medical educators is essential and must be seen and supported as a service priority necessary to ensure patient safety. Where education is good and well supported, hospital outcomes improve. There are published, peer reviewed statistical research papers on this. We can share them if there is interest. We believe that organisations especially employers through their governance structures have a responsibility to make sure educators, medical students and doctors are supported in their learning, including protecting the time needed to develop and learn.