PART

Exploration of the Concept of Evidence-Based Practice and Related Practical Challenges

Chapter 1  Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement  ........................................ 1

Chapter 2  Overview of the Key Concepts and Guiding Principles of EBP as Applied in Sexual and Reproductive Health Care ................................................................. 29

Chapter 3  Systematic Reviews: Consolidating Research Evidence for EBP ............................................................ 49

Chapter 4  Evidence-Based Practice: Practical Challenges in the Implementation Process ......................................................... 71
Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement

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CHAPTER OBJECTIVES

The main objectives of this chapter are to:

- Examine and clarify the concept of evidence-based practice (EBP)
- Explore what clinical governance entails
- Identify each of the core components of clinical governance
- Examine the ways in which those core elements interrelate with the principles of EBP

Introduction

Clinical governance—a U.K.-based health services accountability system—is rather complex. It is underpinned by evidence-based practice (EBP) that are incorporated to achieve standardization of high-quality care and service provision. Moreover, health systems in the United States strive to incorporate EBP into practice. To meet expected professional standards, practitioners must understand the link between EBP and clinical governance. Thus, practitioners should examine the rationales for the core elements of clinical governance together with the principles of evidence-based practice. Therefore, the rationales for clinical effectiveness, education and training, research and development, clinical audit, openness, risk management, and information management are presented in this chapter.

Similar principles conveyed in the U.S. National Strategy for Quality Improvement are also presented. Practitioners are encouraged to consider these concepts and principles in tandem as they try to fulfill organizational requirements for care and service provision. It is necessary, as well, to carefully examine the complexity of accountability and shared responsibility among multidisciplinary teams of sexual and reproductive care and service providers.

Concept of Clinical Governance Explained

As stated, clinical governance ensures the quality of sexual health care. Essentially, clinical governance represents joint responsibility and accountability for clinical success. Thus, professional self-regulation and practitioner judgments should not be replaced by clinical governance because these are critical components of health care and promote high-quality clinical care.

In its 2013 description of clinical governance, the U.K. Department of Health (DH) used the original definition of the concept, placing emphasis on the organization’s accountability for realization of excellence in healthcare. Three essential elements are included in the DH’s definition of clinical governance:

1. High standards of care
2. Continuous and effective improvement in care and services
3. Optimal patient outcomes

Joint responsibility and collaboration of activities within the organizational systems are crucial to realize the desired standards of care and service delivery. Thus, the concept of “integrated governance” is currently advocated by the healthcare organization as a more apt conception of governance in its entirety. Various documents have been published to clarify key elements of good integrated clinical...
governance, including the updated versions of the Healthcare Quality Improvement Partnership's Good Governance Handbooks (Bullivant, Burgess, Corbett-Nolan, & Godfrey, 2012; Corbett-Nolan et al., 2015). Integrated governance represents a system within healthcare organizations that embraces integrated schemes of “management of inputs, structures and process,” which ensure clinical excellence by striving to achieve effective outcomes of care and service delivery (Bullivant et al., 2012; Corbett-Nolan et al., 2015; Department of Health [DH], 2013a; Som, 2004).

**Accountability, Leadership, and Concerted Decision-Making**

While accountability does not feature as one of the seven core elements of clinical governance, it does, nonetheless, thread through the core elements. The clinical governance framework sets out indicators for continuous improvement of health care through evidence-based practice to achieve better outcomes for patients and other service users. This fundamental aim assures the general public by maintaining confidence and trust in the healthcare professions and the services provided. Professional codes consistently remind practitioners of not only their ethical and moral responsibilities and duties but also their legal obligations. The operational structure of a healthcare organization lends itself to an obvious hierarchical system with varying levels of accountability. In the United Kingdom, accountability cascades from the Department of Health to the healthcare units, even down to the patients, care providers, and their representative groups, relevant service users, and the stakeholders. Allen (2000) describes downwards accountability, upwards accountability, and horizontal accountability, with upwards accountability taking precedence. The actual mechanisms that influence accountability depend on the nature of answerability, the associated resource implications, and other factors. In relation to clinical governance, Allen (2000) noted that clinical governance would broaden practitioners’ accountability beyond their existing schemes of legal and professional accountability. However, there exists an inherent ambition among the healthcare professional disciplines to establish distinctive delineations of their specialism. This can create obstacles for a unified or shared accountability among multidisciplinary teams.

Savage and Moore (2004) pointed out the National Health Service’s (NHS) encouragement for collaboration among healthcare professionals in the realization of more flexible role boundaries. These authors contend that accountability becomes obscured where role boundaries are blurred. There is clearly a need for more thorough exploration of the changing roles, professional autonomy, and accountabilities of nurses and other practitioners within the framework of clinical governance. The domains of accountability are explained later.

**Mechanisms That Shape and Regulate Professional Accountability**

The mechanisms relate to answerability in terms of who is accountable and to whom. The tiers of accountability within the healthcare system differ in different countries. Readers are advised to explore the relevant system in the country in which they live and work to understand local policies regulating practice. A brief overview is provided here relating to the U.K. system.

**Systems for Standardizing Accountability**

Particular formal schemes have been instituted that hold the providing organizations to account through a system of regulators. The key regulatory body in the United Kingdom—the Care Quality Commission (CQC)—regulates health service providers, while the NHS Foundation Trusts operate in a rather independent capacity. Therefore, while the current clinical commissioning groups (CCGs) commission their services via contracts, the regulation of the Foundation Trusts is undertaken by a different regulatory body. Professional regulators are independent, and their principal responsibility is to protect the safety of the general public and regulate the quality of care that practitioners provide to patients. The professional regulators are responsible to Parliament, which registers and regulates the training practices of each of the different healthcare professionals. These professional bodies perform various key roles and responsibilities, including the certification of new practitioners. They have the responsibility of ensuring that practitioners maintain standards and remain fit to practice (National Health Service [NHS], 2009).

At the local level, NHS commissioning boards are accountable to involve and report to the public any plans for specific health services. Furthermore, they are expected to report proposals for changes in the provision of services and to report decisions that may affect the ways in which the services operate. The current CCGs are also under legal obligation to report publicly on the ways in which they involved the public in their various activities and decisions. Similarly, they have an obligation to report on how their consultations with the public impacted their decisions (DH, 2013a; NHS, 2009).

Individual practitioners are expected to report proposals for any changes in the provision of the services as well as reporting decisions that may affect the ways in which the services operate. The complex nature of accountability within the wider context of the health service organization is quite recognizable, and the perspective of the individual practitioner should be made clear. Allen (2000) maintains that the legal obligation for the individual professional to provide a high standard of care will always exist in healthcare provision. Statutory bodies of the different professional disciplines provide additional mechanisms and support for regulating and monitoring professional conduct, performance, and
accountability (e.g., the General Medical Council [GMC], the Nursing and Midwifery Council [NMC], and the general social care council). These bodies regulate issues that may adversely affect the standard of patient care and outcomes, such as professional negligence. Moreover, they hold other disciplinary powers in dealing with matters relating to misconduct, malpractice, and other misdemeanors in professional practice (Allen, 2000; General Medical Council [GMC], 2013; Nursing and Midwifery Council [NMC], 2015; Savage & Moore, 2004).

Tension arises where clinical governance advocates collective responsibility for quality care provision and professional accountability. Additionally, clinical governance advocates the notion that groups of professionals should be accountable to one another regarding each other’s performance (Allen, 2000). Clearly, there is a need for thorough exploration of the changing roles, professional autonomy, and accountabilities of the practitioners.

**Ambiguity in the Interpretation of Accountability**

Krautscheid (2014) noted that the multiple levels of responsibility within the healthcare system have resulted in variations in the domains and dimensions of accountability. The multiplicity of the professional disciplines also creates varied perceptions of accountability. Distinctions in academic and professional qualifications create apparent elitism and differences in perception associated with the traditional inflexible demarcations among the professional disciplines. In many areas, these are perpetuated by the disconnected and exclusive post-registration (post-graduate) continuing professional development activities. As a result, a somewhat hierarchical view exists among healthcare professionals that certain levels of responsibility and accountability are more significant and therefore command more respect than others (Savage & Moore, 2004).

There is clearly a need for clarification of the domains of accountability, and a brief overview is presented here.

**Domains of Accountability**

The domains of accountability are explained as follows:

- **Process accountability**, which emphasizes that appropriate systems should be used in the delivery of care for the right patients at the right time and in the right way in fulfilment of the governance principles. The applied system should be carefully recorded. That means that care delivery procedures must be based on appropriate, nationally stipulated guidelines and policies, and approved local standards must be adhered to in structured and coordinated care provision. In this way, process accountability allows for professional self-assessment of performance against the set standard.

- **Program accountability** is the mechanism of quality improvement relating to specific activities, including development of annual reports, and the coordination and dissemination of findings from clinical audits conducted within particular areas of care and service provision (Allen, 2000).

- **Structural accountability** occurs in financial resourcing and collaborative implementation of the clinical governance agenda and principles (Royal College of Nursing [RCN], 2008; Savage & Moore, 2004). The employers/service providers and commissioners have a responsibility to invest in their employees who form the multidisciplinary teams of practitioners. This ensures that the practitioners gain adequate familiarity with the stipulated employment standards, policies, procedures, and guidelines. The individual professionals have the obligation to acquire the essential knowledge and development of their roles and responsibilities. Appropriate provision should therefore be made for the necessary education and training support with opportunities for continuing professional development (RCN, 2008). Provision of such resources serves as a means to clarify any uncertainties about professional and legal accountability, and practitioners should be aware of their obligations in different contexts (Savage & Moore, 2004).

Savage and Moore (2004) examined the ways in which accountability is interpreted among healthcare practitioners and noted that in certain specialties, such as family planning and contraception services, where the practitioners frequently have to make immediate decisions to take urgent actions, they may find themselves confronted with conflicts of interest. Practitioners face the challenge of not overstepping professional boundaries in situations of compliance with the moral, ethical, and legal obligations imposed by the employer–employee relationship and their accountability to the professional bodies/regulators. It is therefore important to carefully examine the accountability statements in the internal policy guidelines as well as the expectations and recommendations of their professional bodies/regulators.

The challenges of having multiple leads in an interdisciplinary team should be carefully explored in the context of shared accountability and shared responsibility. That shared accountability would require establishing ongoing interdisciplinary communication in the team’s working relationships. This would help facilitate decision-making while minimizing the risk of clinical errors caused by inaccurate unilateral decisions. The role and responsibilities of a team lead or manager should be made clear to all members of the multidisciplinary team. There is no doubt that lack of clarity about multidisciplinary team leadership and accountability, answerability for roles, and responsibilities can hinder achieving these principles.

**Collaboration, Collective Responsibility, and Accountability**

It is important for practitioners to understand the principles of professional collaboration, shared responsibility, and
The notion of joint decision-making should be thoroughly examined. Additionally, collaborative decision-making in partnership with healthcare professionals, the patients, their care providers, representative groups, and relevant stakeholders (RCN, 2008) is crucial.

Shared accountability should involve sound communication and joint decision-making strategies. Specifications of practice protocols; care interventions; and departmental, unit, or ward policies should involve input from team members of the various professional disciplines to achieve collective decision-making (O’Grady & Jadad, 2010). In addition to organizing meetings to obtain staff viewpoints, some staff members may be contacted individually for their input. Lack of familiarity with identified patients’ special needs, diagnostic appraisal, and the complexity of holistic interventions could result in limited contributions to team decision-making (Allen, 2000; RCN, 2008; Savage & Moore, 2004). Consequently, individuals may have reservations about the expectation to participate in decision-making activities.

**Accountability and Decision-Making: Potential Implications of Independent Decision-Making**

Decision-making in the multidisciplinary team context involves members of staff of varied professional backgrounds functioning at different levels, inevitably constituting varied levels of input. Staff members with higher or more advanced expertise tend to hold positions of leadership and/or authority. They are therefore likely to be perceived as having the required professional knowledge to initiate and lead key decisions about patient care or deemed to have the professional authorization and accountability to make decisions. Moreover, they are recognized as having the status and professional readiness to accept the consequences for the decisions and actions taken (Savage & Moore, 2004).

**Leadership and Accountability**

Leadership occurs at all levels of the health service structure and therefore the principles of shared accountability and joint decision-making should be addressed at each level. This is particularly complex at the clinical practice level in a multidisciplinary team. The notion that team leads should be the only ones to make decisions or take particular actions for which they can claim accountability and answerability is debatable. Team leads may show bias in decision-making or make an error in suggesting action to be taken (O’Grady & Jadad, 2010).

**Concerted Decision-Making**

The notion of joint decision-making should be thoroughly explored, and the benefits, risks, and alternatives carefully considered. To achieve efficient participation, productive meetings, and accurate clinical decisions for efficacious outcomes and improvement of patient care and safety, consider the following questions carefully:

- What criteria should be in place for determining which members of staff will attend specific shared decision-making meetings?
- Which stakeholders should be invited to attend meetings of specific collaborative decision-making in partnership arrangement?
- What key factors should influence the timings for each of these meetings?
- What issues should be appropriately considered for collaborative decision-making in partnership arrangement with stakeholders?
- What should be appropriately considered for collaborative decision-making in partnership arrangement with stakeholders?
- What clinical interventional issues in terms of care and procedural interventions, policies, and protocols should be considered for shared decision-making by the team of professional practitioners?
- What what is the appropriate timing for these meetings?
- How much collaboration in decision-making is practical and realistic within the multidisciplinary team context of care provision?

**Reflective Considerations**

**Main Benefits of Concerted Decision-Making**

The main benefits to a concerted decision-making process are the following:

- Collective ideas enhance mutual respect and consideration of each individual’s contributions, thus fostering a sense of personal responsibility within the team.
- The processes encourage interdisciplinary cooperation, empowerment, and increased staff motivation to participate in decision-making activities and in implementation of actions.
- Integration of multidisciplinary perspectives in the interventional and policy decisions ensures achievement of more effective outcomes.
- Collective policy decision-making encourages motivation and commitment to implement strategies to achieve the desired standard of quality care provision.
CHAPTER 1 Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement

- Shared and concerted decision-making fulfills team ownership of the outcomes from the decision-making activities and it fosters the confidence to acknowledge related responsibility and answerability.
- Collaborative decision-making yields more impartial and constructive evidence-based interventional actions, and better patient outcomes.

The multidisciplinary team should acknowledge their responsibility to accomplish the principles of quality care provision in terms of patient safety and compliance with set standards toward effectiveness. Admittedly, a significant responsibility of the service providers, the regulators, and the service commissioners is the provision of efficient and sustainable services and support. The aim is to ensure delivery of the desired standard and quality of patient care (RCN, 2008). However, practitioners must be aware of employer requirements as well as responsibility to their statutory professional body. Savage and Moore (2004) identified the need for a consensus statement by the main professional regulatory bodies to provide clarification of the type, level, and boundary of accountability of the different disciplines. The emphasis on team-based working suggests multidisciplinary decision-making, which threads through the components of both EBP and clinical governance. The equivalent governance initiative in the United States, the National Quality Strategy (NQS), is examined in the following section and a boxed detail of the United Kingdom’s parallel approach is also presented.


Like the United Kingdom’s Department of Health, the United States’ HHS upholds equivalent principles conveyed in its NQS. This evolved from the Patient Protection and Affordable Care Act (PPACA) or, concisely, ACA (2010), that pledges the intent to increase, expand, and support accessibility for high-quality affordable health care for all Americans (Agency for Healthcare Research and Quality [AHRQ], 2011). The NQS slogan “Working for Quality: Achieving Better Health and Health Care for all Americans” (U.S. Department of Health and Human Services [HHS], 2014) conveys this goal. The HHS endorses collaborative efforts that draw together federal and state government agencies, healthcare payers, purchasers, providers, consumers, and other affiliates in a framework for healthcare quality improvement.

Key Organizations

Key organizations participating in this framework comprise the California Department of Health Care Services, together with various HHS agencies, including the Centers for Medicare and Medicaid Services (CMS). These organizations have adopted, interpreted, and translated the aims and priorities of the NQS as the basis for developing their particular healthcare quality improvement policies. They represent the key leading providers of health care and services for a larger population of Americans; therefore, the healthcare quality improvement strategies that they advocate are widely influential.

The NQS upholds the value of partnership in care provision that is underpinned by best available evidence. Consequently, joint participation comprises the different states; licensing, healthcare professional specialty, and accrediting organizations; consumers and their advocates; and private sector purchasers. Collaboration in various healthcare initiatives among the stakeholders is also advocated to address specific issues including prevention of healthcare-associated infections and accountability in care provision and to implement community preventative activities.

Currently, several U.S. systems exist for measuring healthcare quality improvement and for interpreting and evaluating performance, which creates confusion for providers, payers, patients, and consumers alike. The need for consistency resulted in the establishment of the Measurement Policy Council, which examined the numerous existing measures to establish a streamlined system. Their focus for improved systems of measurement include control of hypertension; prevention of hospital-acquired conditions and coordination of patient care; patient experience; smoking cessation; perinatal care; human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS); obesity; and depression.

NQS Aims and Priorities

The original NQS published in 2011 (AHRQ, 2011) and updated in 2014 outlined three key aims and six priorities in its guiding principles. U.S. practitioners should understand how the key elements and related principles have been interpreted and applied by their employing healthcare organizations, as slight variations may exist among purchaser/provider, and state and local organizational policies and regulations.

The three aims are as follows:

1. Better care: patient-centered, reliable, and accessible care and services, as well as improved patient safety
2. Healthy people/healthy communities: evidence-based, sanctioned interventions targeting behavioral, social, and environmental health factors
3. Affordable care: lower-cost, good quality health care

The six priorities are as follows:

1. Reducing harm with safer care delivery
2. Partnering with individuals and families in care provision
PART I Exploration of the Concept of Evidence-Based Practice and Related Practical Challenges

3. Using effective communication and coordination of care
4. Using the most effective prevention and treatment practices for the leading causes of death, particularly cardiovascular disease
5. Working with communities to foster best healthy living practices
6. Ensuring affordable, good quality health care by innovating new models of healthcare delivery

The Ethics and Standards of Patient Care Principles

Evidence-based practice principles, clinical governance, and the NQS cannot be addressed discretely in healthcare practice, as they share professional codes of conduct, standards of performance, and ethical principles for high-quality patient care. Common among them is the inherent ethos to take account of the concerns, views, and values of the individual patient, care providers, and the general public. An important practitioner obligation is to ensure that inadvertent negligence as well as inappropriate and inefficient care and service provision are avoided. Simply going through the motions of responding to the requirement to implement EBP is bound to fall short and fail to achieve expected outcomes. Each part of the healthcare organization—for example, the sexual health care and service providers—should aim to devise more carefully thought out, sustainable strategies to implement EBP.

Implementation of EBP in the NQS

In examining the “Efforts to identify and disseminate effective interventions in the United States,” Biglan and Ogden (2008) single out the Blueprints for Healthy Youth Development project as the most efficient and productive scheme for circulating EBPs. Specific selection criteria are applied by the reviewing agencies/researchers. Moreover, in 2001 the HHS advocated the Substance Abuse and Mental Health Services Administration’s (SAMHSA) approach to identifying evidence-based interventions as the selection benchmark. SAMSHA stipulates that the intervention deemed most effective should be the consensus among experts based on their understanding of theory, research, and practice. The views of key community prevention leaders and identified cultural leaders are also acknowledged. Careful consideration is given to the dissemination process to ensure effective implementation. The selected sites for implementation should have essential resources, commitment, staff training, provision of technical assistance, and effective ongoing monitoring of compliance and consistency of implementation (Biglan & Ogden, 2008). In addition to these guiding principles, the individual characteristics for each setting should be carefully considered, and a combination of different strategies may have to be used to implement EBP (Shojania & Grimshaw, 2005).

Titler’s (2006) definition and critical examination of EBP in the United States are largely comparable to that of the United Kingdom. Scientific evidence from empirical research based on randomized controlled trials together with descriptive and qualitative studies are emphasized, as well as case reports, scientific principles, and expert opinion. The following are the key objectives of the AHRQ’s model of the stages of knowledge transfer:

- Development and refinement of knowledge
- Dispersal and distribution
- Organizational adoption and implementation

The Patient Safety Research Coordinating Committee is particularly important in accomplishing these goals. As Titler and Everett (2001) explain, the Translation Research Model postulates that adoption of innovations is influenced by four key factors: (1) the type and strength of evidence in terms of identified clinical topic, (2) the method of communication or dissemination, (3) the particular users of the evidence, and (4) organizational system or context of care delivery—for example, the social system.

Comparable Elements in the Clinical Governance

Comparable elements in the clinical governance are that key parties for joint participation in the provision of care and services include commissioning organizations, local authorities, professional organizations, practitioners, and the voluntary sector (DH, 2013a). The shared objective is to improve the sexual health not only of individuals but society at large by targeting sexual health inequalities and better outcomes. At the same time, the aim is to establish an open culture based on honesty and transparency. It also aims at empowering individuals to make informed and responsible decisions and choices in their sexual relationships while recognizing the impact of poor sexual health on local communities (DH, 2013a).

Clinical governance in the U.K. framework emphasizes the responsibility of the NHS commissioning boards and other commissioning organizations to continually improve and maintain high standards of care and services. That means providing a nurturing climate of excellence in clinical practice with identification and prioritization of the education and development needs of practitioners to ensure an appropriately skilled workforce. The importance of establishing systems to support EBP in terms of clinical effectiveness and research governance is emphasized (DH, 2013b; Sably & Donaldson, 1998).

In addition, clinical governance portrays a milieu for clearly observable high standards of quality care delivery. It is characterized by an obligation to maintain standards as well as active and ongoing improvement (Bullivant et al., 2012; Corbett-Nolan et al., 2015; DH, 2013b; Galbraith & Department of Health, 1998).
CHAPTER 1 Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement

Seven Core Elements of Clinical Governance

The seven core elements of clinical governance are the following:

1. Clinical effectiveness
2. Education and training
3. Research and development
4. Clinical audit
5. Openness
6. Risk management
7. Information management


Similar key elements are outlined in the DH (2013b) sexual health clinical governance document, grouped into three broad areas: (1) patient safety, including incident and risk management; (2) clinical effectiveness, which includes EBP, National Institute for Health and Care Excellence (NICE) guidance, clinical guidelines, clinical audits, education, and training; and (3) patient/public experience, which includes patient/public needs, consent, patient/public information, and complaints management.

These elements ensure that integrated clinical governance becomes an achievable and transparent operation. Each key element is examined in the following sections and their interrelationship with EBP is explored.

Clinical Governance and EBP Implementation

An evidence-based culture ensures that care provision is underpinned by substantiated evidence. Although skepticism persists among some experts regarding what counts as evidence in EBP, a broader view is generally tolerated in current practice. Thus, expert opinion, endorsement of practice by an authorized professional body, or organization and committee reports also constitute substantive evidence. Evidence from clinical experience and practitioner performance should be consistent with other factors. The circumstances, requirements, and personal preferences of patients or identified groups of care and service users may also constitute acceptable forms of evidence if indisputably substantiated (Harris et al., 2001).

Findings from systematic reviews provide insight into the best available evidence and serve as the basis for EBP. Therefore, in addition to professional knowledge and competence, evidence-based practitioners must acquire expertise in the critique of research and appraisal of systematic review reports, which enables them to efficiently explore the best available evidence for treatment interventions, the most effective mode of administering particular treatments, timeliness for interventions, and the most suitable environments.

Therefore, effective dissemination of such information both formally and informally by various means, including written and verbal processes, is crucial in clinical practice. It also requires making relevant data available in comprehensible language to all concerned. Practitioners should develop an understanding of systematic reviews and meta-analyses. Reasonable statistical knowledge and skills for interpreting and synthesizing data from research and clinical audits is also important. Training for such activities may be coordinated at the organizational level, unit, or in-house level to prepare practitioners for undertaking EBP with confidence and efficiency.

Broughton and Rathbone (2001) maintain that the likelihood of guidelines being followed depends on the way they are formulated, the processes of application involved, and the effectiveness of supervision. These elements of EBP are examined together with the core elements of clinical governance to establish the rationale, significance, and the interrelationship in the principles. In the next section, specific components of the 2013 changes in England’s NHS are examined.

Implications for Specific Organizational Changes

Although the following outline represents the U.K. context, practitioners and readers in other countries are encouraged to understand the regulatory structure and commissioning of their healthcare and service provision. In particular, readers are encouraged to investigate how equivalent principles of clinical governance are translated and linked to EBP nationally and internationally.

• The main changes emphasize who has responsibility for making the most crucial decisions about the services and who has responsibility for commissioning providers and allocating funding. The regulating and monitoring responsibilities are also specified.
• Since April 2013, the primary care trusts (PCTs) have been replaced by newly formed commissioning bodies, and CCGs have assumed most of the functions of the PCTs. Additionally, the CCGs have responsibility for the services provided by general practitioners (GPs), nursing, and other health professionals. They also have authority to contract service providers who are considered to be cost-effective and efficient contributors to meet the predetermined NHS organizational standards. This means that providers must fulfill the expected requirements of high-quality care and services. They are expected to respond to the guidelines and recommendations issued by NICE and CQC.
• The commissioning organizations must also demonstrate that they involve stakeholders, including
patients, care providers, and members of the general public, in decisions about the commissioned services.

• The NHS commissioning boards undertake responsibilities that include ensuring improvement of the quality of care and outcomes, contracting of primary care and specialist services, and allocation of resources. Providers within the NHS are expected to register with the CQC as well as with Monitor—the health sector regulatory body in the United Kingdom—to be eligible to function in the capacity of providers of healthcare services.

• Monitor has the responsibility of regulating the providers of health and adult social care services. Professional regulation continues to be undertaken by the relevant professional bodies including the GMC, NMC, General Dental Council, and the Health and Care Professions Council. The Department of Health, however, retains its official leadership responsibility for both the health and social care systems.

• The role of the local authorities has now expanded and in addition to contracting providers, their current role incorporates public health responsibilities together with the related budgeting.

• Health and Wellbeing Boards have the responsibility to facilitate integration of commissioned health and social care services. These boards are intended to strengthen the working relationships between health and social care while also boosting representation of input into key decisions from its own and other perspectives.

• Public Health England (PHE) currently undertakes leadership for the public health team and part delivery of evidence-based public health services across the country. Additionally, PHE is expected to have mechanisms in place to help people make informed choices toward achievement of better health and lifestyle.

• Another organization referred to as “Healthwatch” undertakes a representative role to support public views about the provision of health and social care services. Healthwatch has the responsibility to represent public opinion in specific decisions and report the service users’ experiences. It is expected that Healthwatch England would work alongside the CQC in this role.

In essence, while many functions reflect existing principles, the actual contracting, regulating, and monitoring have undergone significant changes since 2013. These responsibilities are no longer undertaken by PCTs, but by the commissioning boards and the CQC, which regulates health and social care services provided by the NHS Commissioning Boards, the Clinical Commissioning Groups, local authorities, and private and voluntary organizations.

To supplement the (2013a) Framework for Sexual Health Improvement in England, the DH developed Sexual Health–Clinical Governance (2013b). Examining the section on “Improving outcomes through effective commissioning” is particularly useful for more insight about the regulation of care and service provision. What each of the key elements of clinical governance entails is examined here.

Clinical Effectiveness

Clinical effectiveness was launched under the ideals of the quality improvement campaign as a means to measure and report on the efficacy and proficiency of the system of management. In essence, clinical effectiveness affords a means to measure not only the efficacy of treatment interventions but also the related economic value, and ensures that clinical practice undergoes continuous improvement and that patient and care provider welfare is safeguarded. Clinical effectiveness is generally considered as representing the extent to which clinical interventions fulfill their intended purpose. However, a more pertinent conception was later proposed that emphasizes the use of expert/specialist knowledge, emerging research evidence, sanctioned or approved clinical expertise, and patient choices for the realization of best practice (DH, 2013b). The challenge for practitioners is how to determine clinically effective care and service provision. The essential components as defined by experts are summarized here.

Essential Components and Requirements of Clinical Effectiveness

The key principles are described in these terms (DH, 2013b):

• Doing the right thing
• For the right person
• In the right way
• At the right time
• At the right place (within the right environment and facilities of care provision) with the aim of achieving the best possible outcomes
• At the right cost

The essential requirements are the following (DH, 2013b):

• Developing a culture of evidence-based practice within the organization
• Ensuring appropriate professional competence and relevant skills
• Providing treatment/services when the patient needs them
• Ensuring appropriate environments and accessible locations of treatment/services
• Maximizing health gain for the patients/clients in terms of clinical effectiveness
CHAPTER 1 Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement

- Effective communication system with effective diffusion of information among the professional practitioners and the patients/clients
- Ensuring effective implementation of standards, clinical guidelines, protocols, and recommendations
- Achieving effective outcomes
- Ensuring efficient use of resources for the achievement of cost effectiveness
- Responding appropriately to the obligatory requirement of regular clinical audits

Outcome measures should reflect both positive and negative effects of specific clinical interventions on the recipient. Nevertheless, directly attributing a patient’s state of health to a specific intervention could prove to be complex or even impossible. The issue of cost effectiveness is determined through the predictions of health economics whereby effective use of resources, financial disbursement, and expenditure are examined in detail. This principle of clinical effectiveness advocates efficient use of resources in the provision of high standards of care with positive interventional outcome(s) (DH, 2013b).

Assessing and providing trustworthy information about a particular aspect of health care through service evaluation enables the patients and care providers to make confident decisions and choices in their uptake of that service. Feedback from healthcare service users informs practitioners and organizational managers through the care recipient viewpoints.

Clinical effectiveness also requires practitioners to use critical thinking to ascertain if the desired standards and level of performance are being achieved and where appropriate changes to care provision are necessary. From the organizational level to the multidisciplinary team and individual practitioners, all are accountable and are overseen by the National Service Framework (NSF) and NICE, the key authorized bodies providing appropriately substantiated recommendations (Bullivant et al., 2012; Corbett-Nolan et al., 2015; Starey, 2001). However, in order to achieve successful outcomes from any clinical effectiveness audit, meticulous assessment and discussion among the multidisciplinary team of professional practitioners becomes necessary (Box 1-1).

**Evaluation of Clinical Effectiveness**

In the evaluation of clinical effectiveness, all key aspects of the project should be critically examined. The complexity of the challenge is created by the different groups of service users, including the patients, care providers, and their related representative groups. Nevertheless, economical use of resources and cost effectiveness should be demonstrated in meeting the expected goals of care and service provision.

Clearly, clinical effectiveness audit projects provide a means of assessing the degree to which set standards have been achieved. At the same time, the process allows for judging the degree of improvement achieved in relation to specific performance indicators. Thus, clinical effectiveness projects foster team cohesion and enhance decision-making among the organizational board of managers, the various stakeholders, and the clinical care providers. Moreover, the principles provide effective means of disseminating recommendations (DH, 2013b).

Similar to the United Kingdom’s clinical governance, the U.S. NQS stipulates 10 key principles to guide achievement of the three aims mentioned previously.

**BOX 1-1 Clinical Effectiveness Audits: Main Issues Taken into Consideration**

The following list offers questions that can guide clinical effectiveness audits.

- What issue, aspect of care, or topic has been identified for the clinical effectiveness audit project?
- What was the incentive or trigger for considering this project?
- Is the topic or problem significant enough to be prioritized at national level for a clinical effectiveness project?
- Has there been clear evidence of best practice published in the recommendations and/or guidelines of the field to indicate a need for this audit project?
- What proportion of patients and/or practitioners are affected by the problem?
- Is there any indication that patients and/or staff are at high risk due to the problem?
- Who else has previously expressed concerns about the problem and proposed a clinical effectiveness project?
- In what way is it envisioned that clinically effective care can be realistically improved further?
- To what extent does this incentive for clinical effectiveness audit project receive the support and commitment of the multidisciplinary team?
- How realistically can the required change be effected if the problem is confirmed to exist and deemed to be significant enough to warrant a clinical effectiveness audit project?
- What potential ethical considerations are likely to emerge that would need to be addressed?
- How confident is the team about its efficiency and competence to undertake a clinical effectiveness audit project and make changes for improvement?
- What resources are in place for providing different levels of education and training support for the multidisciplinary team?
PART I Exploration of the Concept of Evidence-Based Practice and Related Practical Challenges

NQS Core Principles

“Working for Quality: Achieving Better Health and Health Care for All Americans” (http://www.ahrq.gov/workingforquality/nqs/principles.htm) stipulates that healthcare delivery should conform to a set of standard principles used by all stakeholders. This approach attempts to achieve better healthcare delivery and affordable health care for all Americans. The 10 principles, in brief, are the following:

1. Person-centeredness and family involvement
2. Specific health considerations
3. Elimination of disparities in care
4. Alignment of the efforts of public and private sectors
5. Quality improvement
6. Consistent national standards
7. Bigger focus on primary care
8. Enhancement of coordination
9. Integration of care delivery

Box 1-2 shows policies and infrastructure that support NQS priorities.

The United States recognizes that potential variations occur in the conversion or translation of guidelines, policies, and principles into practical application. Moreover, there are differences in regulations at state and local health organizational levels. For these reasons, U.S. practitioners are strongly encouraged to familiarize themselves with the stipulations and policy/procedural guidelines of their employer and ensure appropriate compliance. There are several key elements for successful quality improvement (Hughes, 2008):

- Fostering and sustaining a culture of change and safety
- Developing and clarifying an understanding of the identified problem or limitation
- Involving key stakeholders
- Testing relevant change strategies
- Continuous monitoring of performance and reporting of findings to sustain the change.

Generic Questions for Clinical Effectiveness Project Appraisal

The following questions could serve as the basis for appraising a completed clinical effectiveness audit project and for considering further projects. The questions are by no means prescriptive or exhaustive; therefore, they can be adapted to develop a more comprehensive and purposeful evaluative tool for the particular clinical effectiveness audit project.

**BOX 1-2 Policies and Infrastructure for Supporting the NQS Priorities**

1. Payment arrangements offering greater value for high-quality health care, with innovations, evidence-based practices, and professional efficiency. These should be monitored, appropriately measured, and evaluated.
2. Public reporting schemes allow for comparisons of the costs, patient care and treatment outcomes, and patient satisfaction.
3. Quality improvement/technical assistance enhances public and private support of the providers to deliver high-quality health care. This policy requires that the provider organizations, clinical specialty groups, and quality improvement organizations should work together with physicians, hospitals, nursing homes, home health agencies, and other parties. Moreover, this facilitates dissemination of research evidence and sharing of best practice and others’ experiences. The role of the HHS is to contract quality improvement organizations to bring about quality improvement through state and local level collaborative endeavors.
4. Certification, accreditation, and regulation via professional certification by state, federal, and federally authorized accrediting organizations. In their regulatory capacity, the state and federal agencies supervise and monitor provider organizations and facilities to safeguard patient safety through sustained quality improvement measures.
5. Consumer incentives and benefit designs. This policy emphasizes the requirement for clinicians and relevant healthcare practitioners to be well informed about available evidence supporting better health practices and adherence to recommended medications. In relation to this, the HHS advocates value-based insurance models.
6. Measurement of care processes and outcomes. This policy involves the collaboration of public and private stakeholders in devising accurate measures for the quality of health care and services through monitoring quality improvement endeavors and data collection on care delivery, patient experience, and patient outcomes. The HHS advocates the coordination of quality measurement endeavors that address the six priorities of the NQS.
7. Health information technology. This policy relates to extensive use of electronic health records with
Reflective Considerations: Questions for Appraisal of the Clinical Effectiveness Project

- What problem, clinical issue, or aspect of care was the impetus for the current clinical effectiveness project?
- How prioritized within that healthcare organization was the particular issue to achieve outcome improvement?
- How significant is the endeavor toward development of best practice in the specific aspect of clinical care?
- How prioritized is the project toward achievement of set targets, effective use of resources, and provision of the funding allocation?
- What clinical practice guidelines and recommendations were drawn upon to substantiate the decision for the project and from what authorized body?
- What systems of decision-making were employed in terms of group decision-making, open or closed?
- What processes were involved and how were the meetings convened?
- What evidence substantiates the clinical issue for the project?
- If related to services, what system was applied to organizing the services and how were these implemented and delivered?
- What limitations have emerged within the system and how have these impacted care and service provision, professional practice and patient outcomes?
- What health economic technique(s) were employed to assess disbursement of the funding, the cost of specific care and/or services, and equipment/resource use?

(continues)
Reflective Considerations: Questions for Appraisal of the Clinical Effectiveness Project (continued)

- Overall, what significant improvements have been achieved and in which aspects of care and services?
- What system is or should be put in place within the health service organization, units, and the actual contexts of care provision to effectively collect and interpret clinical information that can be used to plan, implement, improve, and monitor the quality of patient care?
- What specific limitations in terms of performance as measured by the practitioners’ effectiveness and efficiency were identified through the project and in what area/aspects of care and service provision?
- What is the anticipated plan of action to be taken to resolve those limitations and achieve improvement and better interventional outcomes for the specific patient/client group?
- Who should be involved for expert guidance and support in setting realistic and achievable goals and for the actual implementation of the plan? (Consider the decision-making system.)
- What measures should be taken to monitor and review the implementation?
- What is the target for submission of the full report?
- To whom should the relevant details in the report be disseminated and in what format (e.g., full details, summarized details, in written format, verbal format, or both)?
- Overall, who should be involved in the relevant decisions and actions at different stages?

Practitioners are encouraged to explore various examples of audit projects that have been implemented in aspects of sexual health care and services. Systematic review reports of relevant clinical effectiveness projects also provide very useful sources to learn from.

Rationale for Education and Training in Clinical Governance

The requirement for continuing professional education and training applies to all qualified healthcare practitioners. Employing healthcare organizations have a responsibility to make it possible for clinical practitioners to fulfill their continuing education requirements.

Requirement for Continuing Professional Development (CPD) Programs

Continuing professional development programs focus on emerging professional knowledge, new developments in technology, and new procedures and skills for upholding professional conduct, ethics, and behavior. Therefore, there should be adequate capacity for training support and supervision of newly qualified practitioners.

New theories and concepts are continually verified and substantiated through ongoing research, thus enhancing the existing knowledge in clinical practice. As Starey (2001) argued, the professional knowledge and practical skills acquired during undergraduate education become outmoded in time. They are superseded by emerging new knowledge, innovative concepts, and more contemporary ways of practice. New procedures emerge in clinical practice through research and advances in medical technology, while changes in society create complex challenges in care and service provision. Consequently, these influence professional regulations, guidelines, policies, and recommendations relating to care and service provision at international, national, and local levels. They also influence expectations in professional practice in terms of conduct, decision-making, and actions.

In view of all these, U.K. practitioner performance has to be closely regulated to maintain the desired improvements in the quality of patient care (DH, 2013b). Practitioners must be mindful of ongoing societal changes and their obligation to continually update their knowledge, their overall professional competency, and their day-to-day practical skills.

The endorses the importance of an appropriately educated and well-informed health workforce to provide the best health care and services to populations worldwide to achieve best health for all. The continuing professional development, education, and training requirements are necessary to encourage and assist clinical practitioners to fulfill their obligation to stay up-to-date with new professional knowledge, technology, and procedures.

Certain CPD courses are generic and cater to education and training needs for mixed groups of professional practitioners and these may be delivered at national and local levels. The NMC’s post-registration education and practice (PREP) stipulated CPD education and training requirements for qualified nursing professionals. This was replaced by the revalidation of registration in 2016. Various other CPD programs are designed for specific disciplines of allied health professionals (AHPs) including physiotherapists, pharmacists, social workers, and occupational therapists. Another emerging concept is the educational conference program, “Nursing in Practice,” launched in April 2016. This is designed to support nurses in the primary care sector who need to further develop and update their professional knowledge and practical skills. The Nursing in Practice programs should help practitioners fulfill
CHAPTER 1  Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement

The continuous search for new knowledge, innovative approaches, and advances in therapeutic interventions to achieve improvement in health. The establishment of centers of excellence ensures coordination of high-standard scientific medical research studies conducted by experts who provide guidance about the economic implications of such accomplishments. They provide information and recommendations to guide practice toward achievement of better patient outcomes. The research and development (R&D) centers of excellence inform the organizational management, practitioners, and service users about the quality of specific aspects of care and service delivery.

Other research activities performed or guided by centers of excellence include exploration of the efficacy of pharmaceutics, outcomes of specific therapeutic procedures involving use of new specialist equipment, and the resource implications. Evaluative research allows for studying the impact of national and local policies and recommendations on professional practice. Moreover, exploration of the service users’ perspectives on the care and services that they receive enables the centers to determine improvements for better patient outcomes and better health. These centers possess the level of knowledge and expertise to facilitate and support education and training activities at local and national levels. They may also provide invaluable expertise to support clinical studies conducted by teams of healthcare practitioners to ensure efficient use of evidence-based findings from research.

Gerrish and Lathlean (2015) reiterate the interpretation of research as an endeavor to produce new knowledge that is generalizable by exploring clearly defined problems/topics through the application of meticulous processes. Thus, research within the context of care and service provision allows for detailed investigations to gain deeper understanding of existing interventions while seeking alternative ways to achieve further improvements. The challenge for the NHS organizations, units of care providers, ancillary departments, and multidisciplinary teams is to acknowledge their responsibilities in this component of clinical governance. Appropriate funding and protected time are crucial for realization of essential research activities. While the NHS organizations embrace the ethos of research governance and the related tenets, managers and practitioners must also embrace their responsibilities to acquire knowledge and competencies.

From January 2013, the health research authority (HRA) replaced the research governance framework for health and social care and took over its roles and policies. The governance stipulated the regulations and protocols that must be complied with for research projects within the NHS organization. It aimed at protecting research participants from potential risks directly associated with the conduct of investigative studies. In this way, it ensured that the principles of health and safety would be conscientiously implemented.

Another aim was to ensure that the ethical review procedures were functional and effective. The governance framework emphasized transparency for ethical approval,
recording, and monitoring of all activities employed in conducting research investigations. That includes respect for confidentiality, anonymity and privacy of each study participant and the general public. It also stipulated that participant information and reports supplied to relevant stakeholders should be clear, unambiguous, and comprehensible in terms of language and use of terminology. Overall, the conduct of the study must be scrupulous and reflect excellence in healthcare professional practice. In assuming the responsibilities of the previous Research Governance Framework (RGF), the HRA collaborates with the Research Ethics Committees (RECs) to execute their new process of assessing governance and legal compliance and in implementing a more simplified approval process to prevent duplication of applications as well as stipulating the policy guidelines and regulation for ethical reviews. Readers are encouraged to examine the requirements stipulated by their equivalent health research authority to make comparisons of key elements in their research governance.

Rationale for Regular Clinical Audits
As Kapp (2006) pointed out, the HHS stipulated the regulations to be applied to all patient safety research and are employed by most U.S. healthcare institutions. The core element of common rule emphasizes protection of human participants.

Clinical audit is defined in the DH (2013b) sexual health clinical governance document as a means of assessing if health or social care is being provided according to the required standards. The DH’s specification of standards for integrated sexual health services recommends the use of clinical audits for indicators of quality outcomes (DH, 2013b). The complex link between clinical audit and clinical governance is conveyed in the statement that clinical audit forms an integral part of the core of clinical governance (Burgess & Moorhead, 2011). Clinical audit offers a system whereby the quality of care provision can be systematically assessed on a regular basis. In the United Kingdom, commissioners may specify the minimum number of clinical audits that providers should carry out annually. It is also recommended that the focus of the audit(s) for each year should be determined at the beginning of that particular year. Therefore, most providers develop an annual timetable or schedule of clinical audit projects (DH, 2013b). Clinicians and other healthcare practitioners are expected to participate in clinical audit projects (National Quality Board [NQB], 2013).

Core Element of Openness
Openness relates to processes of quality assurance that require standard and unacceptable practice to be exposed and subjected to public inquiry (DH, 1998; Staerdy, 2001). The importance of openness is emphasized in the publication, “Openness and Honesty When Things Go Wrong: The Professional Duty of Candour.” Openness provides assurance to the general public that the health service organization is committed to meeting the healthcare needs of the population. Therefore, its collaboration with the departments of public health, the local authorities, and local communities is crucial.

Core Element of Risk Management
Risk management may relate to patients, practitioners and service providers, and the health service organization. Specific statutory regulations ensure that neither the patients nor the practitioners or members of the general public are exposed to potential risks. The system of reporting faults, specific incidents, and slip-ups in procedures that can adversely affect patients has certain crucial advantages. It becomes possible for other teams of practitioners in different units, healthcare sectors, and specialties to learn of the potential risks that may be inherent in their own practices. The 2014 publication, Quality and Safety Governance Development: Sharing Our Learning makes recommendations that commissioners, health service providers, and policy makers may consider for underpinning their local action plans (Health Service Executive, 2014).

Related Policies and Protocols
In both the United Kingdom and the United States, different protocols and policies for guarding against clinical and other related risks are controlled by specific regulations and it is important that practitioners conscientiously comply with the recommended protocols and guidelines. In Scotland, risk management forms a crucial element in the provision of safe and effective care. In the United Kingdom, appropriate guidelines and recommendations are outlined in the Clinical Governance and Risk Management Standards: National Overview. The Healthcare Improvement Scotland replaced the National Health Service Quality Improvement Scotland (NHS QIS) in 2011. One of its objectives is to assure healthcare safety through risk-based scrutiny of care and service provision. Successful management of clinical risks is vital because of the potential impact on individuals’ lives. This can be achieved through correct identification and careful assessment of the possible health impacts, effective system of reporting, careful planning, and meticulous implementation of appropriate measures to minimize or eliminate the risks. Hickey’s (2005) distinction between clinical risk management and patient safety is noteworthy. This author argues that clinical risk management reflects competence and is individual- or clinician-oriented, reflecting a voluntary code of moral, ethical, and personal values, beliefs, and principles. Patient safety, on the other hand, reflects performance and therefore is typically team- and systems-oriented. It is underpinned by regulatory framework and therefore exemplifies a patient-centered orientation. Establishment of the National Reporting and Learning System (NRLS) in 2012 in place
CHAPTER 1 Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement

...en to enhance improvement of the safety and quality of care.

Similarly, in the United States, the NQS Patient safety portfolio emphasizes making care safer by reducing the harm that can be caused in patient care delivery and the costs associated with hospitalizations due to healthcare associated infections. Standardization of the NQS policies and procedures among the different healthcare organizations and hospitals helps to prevent, mitigate, and decrease medical/clinical errors, risks to patient safety, hazards, and the potential harmful effects on patients. The AHRQ provides evidence-based tools that can be implemented to improve patient safety. To evaluate the various components of the patient safety portfolio, quantitative and qualitative measures are used. Outcome data, reporting systems, survey data, and interviews with stakeholders provide the evidence-based information to substantiate development of the policy and procedure guidelines and required changes.

Related publications that examine patient safety and risk management in the U.S. healthcare systems highlight national policies, standards, and protocols for healthcare organizations and hospitals both for inpatient and ambulatory settings. To ensure appropriate compliance with recommended practices and guidelines for patient safety, quality care provision, and risk management as well as avoid potential litigations, healthcare practitioners should seek their employing organizations’ guidance. Recommended publications examining patient safety and risk management policies and procedures for healthcare organizations include the following:


A brief outline of common clinical risks and the main considerations for assessment and analysis of risks can be found in Box 1-3.

**Risks to Patients**

Every practitioner has a responsibility to participate in risk identification and analysis. In order to effectively manage risks to patients, regulations such as the Data Protection Act 1998, the Control of Substances Hazardous to Health (COSHH), and the safe management of healthcare waste were put into effect as protective measures (RCN, 2007). Practitioners have an obligation to comply with these regulations. The ethical codes stipulated by the medical, nursing, and allied health professional organizations serve as important means of regulating practice (GMC, 2013; NMC, 2015). Critical event audits and the patients’ complaint system provide additional means of reviewing and questioning the degree of practitioners’ compliance.

**Risks to Practitioners**

Management of risk to practitioners includes practitioner immunization against infectious diseases, safe work environments, and keeping practitioners up-to-date on safe practice. As previously mentioned, various measures and guidance are in place, including the control of substances hazardous to health and the safe management of healthcare waste (RCN, 2007).

**Risks to the Organization**

Organizational risks are complex, and the impact of risks on the overall performance could have implications for...
patient safety. Variations in staffing levels due to staff turnover and shortages may result in the risk of employing staff rather hurriedly. Without proper detailed assessment of qualifications, extent of practical experience, and level of competence and skills, the risk of poor supervision, errors, and various incidents becomes unpredictable. Employment of highly and appropriately qualified staff is vital in the healthcare system and the practices involving locum clinicians and agency nurses should consistently involve strict scrutiny. The financial position of the organization could create constraints in the employment of staff, as well as the choice and supply of high-quality equipment and other essential resources.

Core Element of Information Management

Information management also forms a significant component of clinical governance. Apart from the standard data compiled about the general population, communities, and specific groups in terms of demographic and socioeconomic profiles, other more personal information is also retained. The sensitivity of specific records relates to the ethical and legal implications that surround them. Patient records contain personal and clinical details that may be required for decision-making on clinical interventions, related guidelines, and policies and recommendations. Accurate collection of those details is crucial to enable the healthcare organization to determine the trend of health problems within the population for which it provides services.

It is important that the collection, handling, storage, and use of all clinical information are addressed with great caution and thoroughness. While regulations such as the Data Protection Act 1998 and the Caldicott principles are in place to protect the confidentiality of patient information, they also allow for controlled use of specific information for research purposes. Similar elements as outlined above also appear as key elements in the United Kingdom's 2013 sexual health clinical governance.

The ensuing sections provide overviews of the national frameworks for improvement in SRH care. The U.S. public health approach to sexual health care is followed by the United Kingdom's SRH framework that is widely recognized as a model/commendable exemplar.

National Framework of Public Health Approach to Sexual Health Care in the United States

The RAND Corporation study (Auerbach et al., 2012) commented on the fragmentation of SRH care delivery and the disconnection from primary care and public health. Nonetheless, the point is made that the public health approach portrays a shift of focus to a broadly integrated health promotion approach to sexual health care (Satcher Hook, & Coleman, 2015). Comprehensive implementation of the sexual health framework should be apparent across multiple levels of the health impact pyramid. Therefore, counseling and education, clinical interventions, long-lasting protective interventions, changing the context to make individuals' default decision healthy, and socioeconomic factors are crucial issues.

For the requisite health impact assessment (HIA), the key elements that need to be considered comprise screening to determine the likelihood of successful sexual health strategy; scoping, to identify potential risks and benefits; assessment of the baseline sexual health of the population; and prediction of the potential health effects. Recommendations of practical solutions with feasible implementation strategies require careful consideration. Reporting ensures appropriate dissemination of the findings to decision-makers, the relevant communities, and stakeholders. Finally, monitoring and evaluation of the changes in sexual health and associated risk factors together with evaluation of the efficacy of the processes and entire HIA are also required. Thus, disease control and prevention features as fundamental in the public health–focused SRH strategy.

The U.S. Centers for Disease Control and Prevention (CDC) prioritized working with prevention partners and providers to identify specific opportunities for sexual health framework to enhance their work (Douglas, 2011). The framework highlights complex factors at the individual relationship, community, and societal levels that influence health outcomes and shape individuals' ability to be sexually healthy across the lifespan. Douglas (2011) examined the rationale and options for the implementation of a national framework within the context of public health. Consultations on this initiative received great support as being appropriate, optimistic, constructive, and empowering. The key recommendations urge the following actions:

- Developing a CDC definition of sexual health and publishing a white paper
- Outlining the key objectives and stipulating the national SRH indicators
- Exploring the right milieu and tone of communication for achieving maximal acceptance
- Convening a national partnership of advocates, including faith-based organizations

Rationale for Establishing a National Sexual Health Framework

U.S.-based sexual health care and services were fragmented due to differences in state legislatures, diverse regulations and policies, and variations in care system structures. The SRH care system has predominantly been operating a disease-focused scheme. It is envisioned that a more contextualized national sexual health framework may encourage more open, normal-
CHAPTER 1 Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement

in schools and at home. A sexual health framework in the public health context has the potential to reach youth and specific population groups and, essentially, the general public at appropriate levels on appropriate terms. Therefore, risk factors associated with adolescent pregnancy should be more extensively explored and carefully addressed. An exemplar of good practice prevention program is the U.S. Navy's sexual health and responsibility program (SHARP) implemented in 2000 based on the existing HIV prevention program.

U.S. Navy Sexual Health and Responsibility Program (SHARP): An Exemplar of Good Practice

The SHARP program is endorsed by the U.S. Department of the Navy; it is mandatory and supported. The program advocates planned pregnancy, sexually transmitted infection (STI) and HIV prevention, and elimination of syphilis. These goals are further enhanced by appropriate clinical care and counseling support, together with partner services, and access to contraception services and condoms. Thus, a strategic and comprehensive approach to sexual health promotion should provide a means of HIV prevention among special groups, including men who have sex with men. It emphasizes extensive education of the American public about HIV prevention and reduction of stigma/discrimination (Douglas, 2011). It is envisaged that the existing U.S. national HIV/AIDS strategy could provide a basis for advancing a public health approach to sexual health that includes HIV prevention. The framework could support, streamline, and enhance existing disease control and prevention using its four pillars of primary focus: (1) healthy and safe community environments, (2) preventive clinical and community endeavors, (3) empowerment of individuals, and (4) abolishing health disparities (Swartzendruber & Zenilman, 2010).

Issues for Consideration in Relation to STI Prevention in the SRH Strategy

Each state must address system-level barriers to timely treatment of partners of persons infected with an STI. This includes implementation of expedited partner therapy for the treatment of chlamydia. Variables, including gender/sex of the infected person’s sex partner(s), are essential to understanding the epidemiology of STIs as well as guiding preventive efforts. Innovative communication schemes are critical in addressing issues of disparities, facilitating uptake of services such as HPV vaccination, and normalizing perceptions of sexual health and STI prevention. In particular, these help reduce health disparities. It is necessary to coordinate STI prevention efforts with the healthcare delivery system to leverage new developments provided by health reform legislation. Social, economic, and behavioral factors that affect the spread of STIs include racial and ethnic disparities, poverty and marginalization, access to health care, substance abuse, sexuality, and secrecy in sexual networks.

The national prevention strategy (NPS) prioritizes SRH and upholds the following principles:

- Appropriate knowledge practices and care are crucial in enabling individuals to fulfill their capability and community stability.
- Safe and responsible sexual practices are associated with reduction in sexual violence, spread of HIV, viral hepatitis, and STIs.
- Planned and healthy pregnancy is vital to the well-being of the mother and child.
- Implementation of effective sexual health strategy could prove significant for addressing the burden of teen pregnancy and related consequences on educational attainment, employment, and financial stability.

The recommendations emphasize the following goals:

- Provision of effective sexual health education for youth
- Empowerment to make informed healthy choices and decisions on the uptake of SRH services
- Enhancing early detection of HIV, viral hepatitis, and STIs for appropriate linkage to care interventions
- Increasing use and uptake of preconception and prenatal care.

Sexual assault prevention is maintained and appropriate response intervention provided together with drug/alcohol abuse prevention (Douglas, 2011). The CDC’s definition of sexual health states: “Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.”

Framework for the United Kingdom’s Sexual Health Improvement 2013

The DH describes sexual health as offering advice and providing services for supporting contraception, relationships, STIs, HIV infection, and abortion. It embraces the complexity of SRH care and services within diverse settings, including general practice settings, community services, acute hospitals, pharmaceutical service, and the voluntary, charitable, and independent sectors. To further improve the sexual health among communities and the wider society, a detailed re-examination and reassessment was carried out to establish evidence-based efficient service provision through appropriate change.

The 2013 framework for sexual health care comprised at its core partnerships and joint participation among the commissioning organizations to accomplish high-quality sexual health services and better patient/client outcomes. This undertaking, described as Joint Strategic Needs Assessments (JSNAs) was supported by Joint Health and Wellbeing Strategies (JHWSs) to fulfill the identified needs.
The evidence-based information obtained was intended to guide the local commissioning of care and services by the relevant local authorities, the NHS commissioning boards (NHS CBs), and the CCGs. The local authorities were expected to commission open-access sexual health, STI, and contraception services to fulfill the requirements of their local communities (DH, 2013a).

The Department of Health acknowledged the improvements that have been achieved over the past few years. Nevertheless, other issues have been identified as needing further attention, such as sexual health-related stigma, discrimination, and prejudices, and implementation of evidence-based preventive measures and treatment initiatives to reduce the rate of STIs. Effective patient/client access to the full range of contraception services and family planning together with guidance and support regarding unwanted and unplanned pregnancies are also identified. HIV prevention with increased access to early diagnosis and early treatment are also considered as requiring further attention, as is integration of cost-effective, evidence-based, high-quality care (DH, 2013a).

Attention to Focal Needs

Taking account of the main sexual health needs of the general population, the measures to improve sexual health outcomes were recognized in the DH (2013a) framework as follows:

- Pertinent, trustworthy, and correct information provided at the most appropriate time for making informed decisions about sexual relationships, sexual health, and sex
- Protective processes to foster empowerment, self-respect, and self-confidence to make informed choices for better health
- Quick or urgent access that is personal and private, integrated care and support by relevant professionals, at opportune times in a variety of settings
- Evidence-based approved and effective diagnosis and treatment of STIs and HIV infections together with partner notification and partner management
- Collaboration and continuity of care across gynecology, antenatal, and HIV care and services within the primary, secondary, and community care sectors in different settings

Issues of Particular Concern

Certain issues of concern included the high incidence of unplanned pregnancies, the persistently high rate of chlamydia among young adults, the high prevalence of HIV infections and late diagnosis of newly infected patients due to delays in seeking consultations, the increasing rate of syphilis, and emerging strains of resistant gonorrheal infections. The high incidence of abortion and the persistence of sexual assaults among vulnerable groups of women at high risk also need to be prioritized for special attention (DH, 2013a).

Areas for Priority Action

In relation to these concerns certain key areas were identified for priority action with specified objectives. These included measures to reduce sexually transmitted infections through provision of evidence-based information, sexual health promotion/education, and support for people of all age groups; implementation of preventive programs, including testing and treatment interventions aimed at reducing HIV infections; and further improvement of contraception services to reduce the rate of unwanted pregnancy among all women of fertile age. Reduction of the abortion rate with counseling support and prevention of teenage pregnancy were also priority areas (DH, 2013a).

Commissioning and the Proposed Changes

The broad context of commissioning (or contracting) involves contribution from the local authority commissioning, CCGs, and NHS commissioning boards. The DH (2013a) framework sets out guiding principles that should be applied in the contracting process by each of the three commissioning bodies.

Role of Local Authorities in Clinical Governance

In their role as major commissioning bodies, the local authorities have to ascertain that the contracting providers have effective clinical governance systems in place. The providers have an obligation to comply with the standards set by authorized organizations for guiding clinical care and service provision. Monitoring procedures are in place, set by the local authorities to ensure that the providers correctly implement all elements specified in the clinical governance principles. This may be a nonmandatory public health services contract set by the Department of Health in collaboration with relevant stakeholders including public health professionals. In addition, the DH has issued a standard service specification for integrated sexual health services that outlines quality indicators and performance measures to be used to ascertain that the principles of clinical governance are properly implemented (DH, 2013a). As part of the tendering process, the local authority commissioners assess the adequacy of the structures and capacity for meeting the requirements of clinical governance. In their role as chief adviser on health for the local authority the Director of Public Health is consulted for advice on the public health perspective of the clinical governance mechanisms. Specialized medical and pharmaceutical contributions are also considered in the contracting and tendering processes. This allows for carefully examining the clinical governance requirements for safe and effective use of medicines in relation to the patient group directions (PGDs).
CHAPTER 1 Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement

Quality surveillance groups examine shortcomings in the quality of SRH care in relation to clinical governance. It is proposed that an informal facilitative process can also be undertaken by the local health and wellbeing board. The establishment of provider events is allowed to encourage open and transparent opportunities for development of new models of care and service delivery. These may help to substantiate new approaches to SRH care and service delivery (DH, 2013a).

Role of Providers in Clinical Governance

Recognition is given to shared responsibility for ongoing improvement in healthcare delivery and for dealing with inadequate or deficient quality standards. Nonetheless, the view of experts is that the ultimate responsibility should be carried by the leadership of the provider organization. A designated lead for clinical governance is recommended for genitourinary medicine (GUM) and reproductive healthcare services. Providers are required to register with the Care Quality Commission, which functions as the statutory regulator to confirm that they are formally regulated SRH care and services providers.

The Department of Health (2013a) stipulates six key guiding principles that the commissioners are expected to apply toward achievement of best practice:

1. Prioritizing prevention of poor sexual health through health-promotion techniques: This draws on insights from behavioral science in adopting change in lifestyle behaviors toward better sexual health.
2. Establishing a strong and effective leadership team should comprise members from each of the three commissioning authorities: Their partnerships with relevant parties from the voluntary and community sectors should help strengthen their commitment to improve sexual health throughout the local area.
3. Focusing on outcomes based on accurate data, determining outcome measures, and carrying out needs assessment: The findings can be used with other best evidence available to plan and implement actions to reduce inequalities in sexual health and well-being.
4. Continuously monitoring the improvement to help in assessing and maintaining cost effectiveness of the interventions and the related services.
5. Carefully examining the wider determinants of sexual health.
6. Considering the associations between sexual health and various factors identified as determinants of health—alcohol, misuse of drugs, violence against women, and mental health.

To ensure their effective implementation, the local authority commissioners are required to register with the CQC, who inspects and monitors the services to see that they are complying with the required standards of care and service provision through the principles of clinical governance (DH, 2013a).

Commissioning of High-Quality Providers of Correct Interventions and Services

These should take place in a variety of settings at flexible times that are acceptable to patients and delivered by appropriately trained, qualified, and well-informed practitioners. Moreover, the interventions should reflect best practice. Therefore, feedback from the service users should be considered important. Provision of high-quality training through approved courses is crucial to prepare and support practitioners for competent performance of their roles. Examples are programs, courses, and modules provided by the Faculty of Sexual and Reproductive Health and the British Association of Sexual Health & HIV. Effective referral systems and commissioned services offered at easily accessible sites are emphasized.

Meeting the needs of population groups at higher risk is another stipulated principle. The vulnerable groups include those with special needs and at risk of poor sexual health as well as people with learning disabilities; young people; the lesbian, gay, bisexual, and transsexual (LGBT) community; and specific ethnic minority groups. This overview of the 2013 Sexual Health Framework attempts to establish links to the core elements of clinical governance previously examined in this chapter.

Patient Group Directives (PGDs): Role Extension of Pharmacists

Two important elements in sexual health care are examined here. To begin with the importance of confidentiality, PGDs are explored as outlined in DH Sexual Health: Clinical Governance (DH, 2013b), followed by the implementation of PGDs.

Respect for Patient Confidentiality

Respect for confidentiality is an important component of professional practice in healthcare. Relevant documents include the National Health Service’s Confidentiality: NHS Code of Practice (NHS, 2003), Confidentiality: NHS Code of Practice Supplementary Guidance: Public Interest Disclosure (NHS, 2010) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The latter provides supportive interpretation of the key principles specified in the code of practice to guide practitioners when faced with decisions of disclosure of patient confidentiality. Practitioners employed in the National Health Service are expected to comply with the Caldicott principles of confidentiality (Brook et al., 2013; Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists [FSRH], 2015). The professional
regulatory bodies also issue guidelines on confidentiality; the Nursing and Midwifery Council, for example, provides The Code: Standards of Conduct Performance and Ethics for Nurses and Midwives (NMC, 2015). These regulatory bodies stipulate standards for safeguarding patient/client confidentiality and dealing with confidential information justifiably, with discretion, honesty, and respect as specified in the Caldicott principles.

In certain situations, however, public interest requires that particular infections should be notified, which may involve disclosure of confidentiality. The rationale for this is to protect the public from the risk of acquiring the infections by putting in place measures to control the rate of spread and acquisition. The United Kingdom’s Faculty of Sexual and Reproductive Health (FSRH, 2015) cautions about violation of confidentiality, mishandling of patients’ records, potential professional consequences, and the possibility of litigation. Therefore, practitioners must be made aware of this and the related disciplinary action in their contracts of employment. Details of patients’ sexual history should not be divulged to third parties, and the preferred mode of correspondence should be respected and used as the individual requests. Furthermore, a practitioner should not inadvertently breach doctor–patient confidentiality by asking an individual’s medical general practitioner to divulge specific personal details. The use of identifiable items including personal details and photographs must be consented by the individual. Various ethical dilemmas arise in relation to the duty of confidence and it is possible that protecting the confidentiality of one patient or the sexual contacts could have damaging consequences for other individuals. The FSRH (2015) outlines standard statements on confidentiality training, the rights of patients to confidentiality, disclosure without consent, duty of confidentiality to young people, sharing, and disposal of confidential information. These are contained in the Service Standards on Confidentiality (FSRH, 2015).

Beckley and Szilagyi (2013) also provide useful insight into the ethical issues relating to detailed health history taking. Practitioners may find it useful to critically analyze these to consider how best these can be interpreted and translated into practical application. It is also useful to reflect on some of the moral and ethical dilemmas and conflicts that may arise in the partner notification process and the potential legal implications.

**Patient Group Directives: Requirements and Processes**

Patient Group Directives are explained in the Health Service Circular (HSC) as “a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment” (Medicines & Healthcare products Regulatory Agency, 2017). This means that a named registered practitioner who is functioning under the regulations of a professional body may supply and/or administer a specific medicine to individuals of identified patient groups. Thus, a formal prescription for a particular patient may not be required. However, the specified set of criteria must be fulfilled in the PGDs guidelines. In SRH care, PGDs are specifically used for the supply and administration of certain types of contraception and for treatment of chlamydia. While PGDs offer quick and easy access to treatment, patient safety is strongly emphasized and must supersede all other aspects of this practice.

**Regulations and Guidelines on PGDs**

The regulation stipulates that PGDs require the signature of registered authorized practitioners—in particular a physician or pharmacist—and they must be endorsed by the appropriate authorizing body stated in the PGD guidelines. Independent and voluntary sector providers may also supply and administer medicines. However, they must be registered with the Care Quality Commission and endorsed by the relevant commissioning body such as the local authorities. It is important that all practitioners involved in PGDs have received the required additional training for this role and be appropriately qualified. Of equal importance, providers must comply with careful reviews and renewal of expired PGDs. Practitioners are encouraged to read the comprehensive guidance issued by NICE in its good practice guidance regarding PGDs and to examine the recommendations for reporting incidents of errors relating to patient safety (DH, 2013b).

**Confidentiality: An Essential Element in Sexual and Reproductive Healthcare**

Apart from situations relating to a criminal offense, the legal regulation emphasizes that information that can identify a patient should not be shared between authorities without the individual’s consent. In relation to STI testing, the degree of safeguarding an individual’s confidentiality is even stricter. A new code of practice developed by the DH and the Health and Social Care Information Center replaces existing regulations and guidelines. The Caldicott (2013) publication—Information: To Share or Not to Share—is highly recommended reading (http://www.gov.uk/government/publications/the-information-governance-review). Practitioners would find it particularly useful to critically examine the data protection act and the guidance on the law and regulations relating to safeguarding the rights, consent, privacy, and confidentiality of individual patients (DH, 2013b).

The Department of Health’s (2013b) Sexual Health: Clinical Governance emphasizes patient safety, clinical effectiveness, and patient/public experiences of sexual health. The main action points relating to each element are stated. The aim is to achieve improved sexual health service provision by maintaining efficient and high-quality services and favorable outcomes (DH, 2013b).

CHAPTER 1 Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement

Rationale for Standardization of the Directives for SRH Treatment

It is important that practitioners are aware of the rigor by which policy regulations, recommendations, and guidelines are developed. Relevant authorities ensure that the best available evidence from various sources is meticulously examined. Within this field, the involvement of SRH professional experts and the stakeholders is also secured. Thus, contributions and reviews are made by GUM physicians and other specialists, sexual health nursing practitioners, sexual health advisers, the association of pharmacists, and relevant patient group representatives.

The key rationale for standardizing the principles, guidelines, and procedures for treatment is to ensure that the treatments provided for specific STIs are based on best available evidence. Moreover, standardization allows for accomplishing control and prevention of spread and recurrence of specific infections among members of the community. Consistency in the application of the recommended evidence-based guidelines ensures efficient management to avoid long-term adverse health, social, and economic consequences. The interactions between sexual health physicians, other practitioners, and the patients help to initiate preliminary measures toward change in sexual behaviors while encouraging uptake of available sexual health services, including screening.

The WHO urges that all countries establish their national standards, protocols, and recommended guidelines for the treatment of STIs. This ensures consistency in care and service provision with all patients receiving the appropriate recommended treatment and support. Moreover, standardization requires that practitioners undergo purposefully designed education and training to acquire appropriate knowledge and skills for efficiency in practice. These are crucial for correct implementation of the different procedures and treatment interventions in all aspects of STI care. Standardized national protocols should reflect carefully assessed epidemiological status and antimicrobial drug sensitivity results among the population of each country. Thus, the expertise and guidance of bacteriologists, biochemists, and pharmacists should be sought. The following section briefly examines the role of pharmacy in the provision of STI and reproductive tract infection (RTI) treatment, care, and support.

Significance of Pharmacy Services in SRH Care and Service Provision

Pharmacy services contribute a crucial role toward the overall SRH care and services. Service provision within the community settings ensures that accessibility to comprehensive pharmaceutical support can be extended beyond the inpatient sector of secondary care and outpatient clinics. In this way, pharmacy services in STI/RTI care clearly demonstrate the concept of integrated primary and secondary care and service provision for the general public. Apart from the practicality and ease of access to obtain prescribed medication, the extended role of pharmacists contributes toward enhancement of care and service provision for SRH patients/clients.

As the pharmacy profession continues to evolve, becoming more clinically focused with specialization in areas such as sexual health, pharmacists are able to provide invaluable specialist support. The Royal Pharmaceutical Society of Great Britain publishes relevant evidence-based guidelines, and readers who are members of the society are encouraged to explore the most current Sexual Health Toolkit publication.

Clinical pharmacists with qualifications up to consultant level may be employed within the HIV care and services sector. Apart from providing specialist advice to the SRH physicians and patients on important aspects of drug therapy, they also monitor safety in drug treatment for the patients. In the United Kingdom, clinical pharmacists may function in the independent or supplementary capacity to prescribers with additional direct responsibility for caseloads and patient management (Royal Pharmaceutical Society [RPS], 2014).

Extended Role of Pharmacists: Significance in Sexual Health Care and PGDs

The extended role of pharmacists incorporates implementation of PGDs. The PGDs policy allows for the supply and administration of prescription-only medicines (POMs) under certain circumstances, and it ensures enhancement of patient care. As mentioned, PGDs may be authorized by the healthcare provider registered with the Care Quality Commission. In practice, the directives may be determined and authorized by NHS bodies such as the current CCG-qualified physicians, dentists, hospitals, and clinics in compliance with legislation relating to the Medicines Act 1968. Pharmacists are in a position to provide support and advice within primary and secondary care in the preparation of PGDs. Additionally, pharmacists may be involved in the development of formularies and the related policies for the management of medicines in community contraception services and local GUM services (RPS, 2014).

Furthermore, community pharmacists may provide a range of comprehensive supportive roles in sexual health services depending on the disbursement of local and national funding. An additional role involves providing advice on, dispensing, and supplying medications and other sexual health products directly to the public. This role may necessitate private consultations in response to increased public demand and the willingness of individuals, specific social groups, and community members to consult pharmacists on sensitive issues relating to STIs/RTIs. The continuously increasing variety of medicines and over-the-counter products invariably necessitates the provision of specialist
advice to sexual health clinicians and practitioners with direct private patient consultations.

Qualified pharmacists who have acquired additional specific qualifications through prescribed specialist training programs in identified clinical areas such as STIs/RTIs and GUM have remits to perform particular roles. These may include managing common uncomplicated sexually transmitted infections by carrying out specific screening and diagnostic tests, such as chlamydia and gonorrhea screening within both NHS and private sectors. Provision of STI treatment in the extended role of the pharmacist may involve dispensing and/or administering treatment for infections such as chlamydia, genital warts, and genital candidiasis. Supply and instructions on correct application of the different types and products of condoms and HBV vaccination are additional potential roles. Other extended remits may involve referral of patients for specialist care and treatment and, to some extent, participating in the process of partner notification and preliminary health promotion (RPS, 2014).

The issue of professional, ethical, and legal importance is that these roles should be recognized as guided and regulated by statutory acts, and the PGDs should be defined by the relevant healthcare providing organization. Compliance with the regulations is obligatory and should reflect the accountability of pharmacists within the wider context of SRH care, particularly STI/RTI care and service provision. Regular reviews of PGDs are stipulated to occur at least every two years. The type and classification of the particular prescription-only medication to which the PGDs relate should be clearly stated and complied with. Moreover, the clinical conditions and indications for which the particular POM can be used to treat and the criteria for eligibility for the treatment or exclusion from it should be fulfilled as specified in the PGDs. There should be clear stipulation of the circumstances for which advice should be sought from a specialist physician or the relevant medical officer. The form of the POM, the prescribed strength and dosage, as well as the mode and frequency of administration must be strictly complied with. Of equal importance, the minimum and maximum duration and relevant precautions relating to the particular POM is vital for protecting the safety of patients. Circumstances for which follow-up action would be required and the related referral systems to be employed for further medical intervention should each be clearly stated in the PGDs and complied with accordingly. Accurate record keeping should be regarded as a professional obligation. The requirement for detailed information should be complied with including the sale, supply, and administration of specific medication under the PGDs regulations.

Details of patient/client assessment should incorporate the information that the individual provides by completing the prescribed pro-forma indicating the name, date of birth, and contact details. Additionally, record should clearly indicate the name of the medication, the dosage, and quantity supplied to the particular patient. The advice and supplementary information provided to the individual including specific leaflets given to him/her should all be recorded accurately together with the date and signatures of the patient and the pharmacist (RPS, 2014).

Participation in HIV and AIDS care and service provision involves working with the multidisciplinary team. The specialist clinical pharmacist may be consulted for advice regarding specific drug treatments and drug interactions. The consultant pharmacist may have a role in post-test counseling while he/she may also be involved in HIV clinical services in the secondary care context and management of medicines in the primary care setting. The pharmacist’s involvement in community HIV/AIDS care and services may entail provision of advice and support to the patients (RPS, 2014).

It is envisaged that the role and contribution of pharmacists in STI care will continue to extend beyond the current policy restrictions to allow for involvement of pharmacists in a wider range of screening tests. HPV vaccination by pharmacists may increase, and the provision of post-exposure HIV prophylaxis may also be considered in the remit of the community pharmacist (RPS, 2014).

### Compliance in Relation to PGDs and POM

The concept of integrated STI/RTI care and service provision within the primary and secondary care sectors aimed at providing comprehensive and accessible care confirms the need for wide-ranging professional expertise. STI/RTI together as a unified structure undergoes constant evolution with fluctuating epidemiologic patterns of the infections and related consequences. The evolving characteristics of different infections should be carefully considered in the provision of treatment, guidance, and support in order to achieve effective outcomes. The range of treatment also varies widely and continues to expand, getting increasingly complex in response to laboratory discovery of resistant microorganisms. Correspondingly, the pharmaceutical industries have had to respond to the emergence of new and more virulent species and strains of microorganisms, viruses, and bacteria. To keep up, the industries are manufacturing more specific/complex drugs with appropriate strength and sensitivity to deal effectively with the emerging strains of organisms. With the discovery of concomitant organisms, the choice of treatments, combinations of antimicrobials, and the mode of administration and the schedules of the regimens have to be constantly reviewed and updated. The emergence of more sophisticated scientific techniques has enabled specialist laboratories to perform more complex tests with more reliable results. At the same time, relatively simple yet sensitive tests have emerged with appropriate...
CHAPTER 1 Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement

All-Embracing SRH Services Across Public Health and Primary Care: Endorsement by the WHO

The WHO’s definition of SRH embraces the reproductive health of men and women throughout the lifespan, as well as preconception, contraception, and pregnancy. Also included are women’s health and routine gynecological care, specialist gynecological assessments such as infertility, men’s genitourinary conditions, and sexual health promotion. The all-inclusive SRH spans across pre- and post-reproductive years and is associated with socio-cultural factors, gender roles, and human rights and protection (WHO, 2011). Aligned with public health and primary care, integrated SRH services should provide the full extent of SRH obligations and accountabilities, including prevention services. Brief outlines of the core competencies of SRH are presented here (Box 1-4).

Domains of the Requisite SRH Core Competencies

Thirteen competencies are categorized into four domains as synopsized here (WHO, 2011):

- **Domain 1** focuses on the practitioner’s knowledge of ethics and principles, which influences all other competencies. Essentially this domain is required for fulfilling the human rights of each patient.
- **Domain 2** represents the leadership and managerial roles and attributes. This domain is intended for program leaders and managers but may also be applicable at other levels. This domain requires managerial responsibility for establishing an atmosphere of high motivation with support for continuing education, facilities, and appropriate resources to provide high-quality SRH care and services.
- **Domain 3** comprises four general SRH competencies for healthcare providers and includes working with the community, health education, counseling, and efficient assessment of the client.
- **Domain 4** comprises seven specific clinical competencies for different types of SRH care provision. This domain outlines a minimum package of care and service provision that is accessible to every individual patient.

Ideally, education and training programs focused on providing efficient high-quality SRH care and services should be consistent at national level. Arguably, certain variations may emerge in implementation at the state level. Nonetheless, key elements in the SRH education and training curricula programs could lend themselves to interdisciplinary teaching and learning. Clinical practice placement opportunities and acquisition of a shared set of competencies in the development of practical experience within the integrated primary healthcare context have received positive recognition (Newhouse & Spring, 2010). The shared competencies that should thread through all the SRH and other programs encompass human attitudes, knowledge, ethics, human rights, leadership, management, teamwork, community work, education, counseling, clinical settings, and service provision. These could be considered key elements in the concept of “interprofessional competencies in integrative primary health care,” examined by Kligler et al. (2015). A careful collaborative effort among the relevant educators, academic institutions, and professional disciplines is required to address variation among the different disciplines (Kligler et al., 2015; Newhouse & Spring, 2010). Berg, Woods, Kostas-Polston, and Johnson-Mallard (2014) examine the concerns about the adequacy of the curricular content of the SRH preparatory education and training programs.

**BOX 1-4 Key Elements of SRH**

- Enhancing antenatal, perinatal, postpartum and neonatal care
- Providing high-quality family planning services and infertility services
- Abolishing unsafe abortions
- Preventing sexually transmitted infections including HIV, reproductive tract infections (RTIs), cervical cancer, and other SRH conditions
- Promoting sexual health
- Increasing capacity for supporting and sustaining research and program development (as construed from WHO [2011] SRH core competencies in primary care)

for women’s health nurse practitioners (WHNPs). They strongly suggest that educators involved in NP primary care specialty programs should carefully examine the adequacy of the SRH content for developing the essential competencies as proposed by the Royal College of Nursing and the WHO. Feedback from graduates could also be obtained to establish their views about the adequacy of their preparatory program for meeting the SRH needs of the men and women encountered in their practice. They also suggest determining if SRH care provision within primary care adequately meets the needs of men and women patients/clients. Collaborating with certification and accreditation programs would ensure creating benchmarks for measuring SRH competencies in the primary care specialties. Offering residency programs should help to enhance the knowledge that primary care NPs acquire (Berg et al., 2014). Wisby and Capell (2005) also examined how sexual health competencies can be implemented and identified challenges relating to the academic and practice contexts as they recognized the increasing interest in interdisciplinary learning.

Conclusion

Challenges relating to the preparation of practitioners for efficient performance and high-quality care in SRH should be continually addressed. Moreover, the potential benefits of interdisciplinary learning and shared common core competencies should be more extensively examined. The perspectives explored in this chapter with exemplars may help practitioners to explore the ongoing developments within national and local levels of health care and service provision. An overview of the ongoing initiatives in the United States to establish a sexual health strategy should be complemented by further exploration of national and state-level endeavors. Practitioners may find it useful to compare developments within the systems of SRH care and service provision in the United States, United Kingdom, and other countries to learn from examples of best practice.

REFERENCES

CHAPTER 1 Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement


SUGGESTED FURTHER READING


CHAPTER 1  Clinical Governance in the United Kingdom and the U.S. National Strategy for Quality Improvement


