JOURNAL OF MEDICAL STANDARDS & ETHIC

12-Pillar Clinical Governance and Good Medical Practice: transforming the whole health sector and system.

Joseph Ana

Center for Clinical Governance Research & Patient Safety (ACCGR&PS).
8 Amaku Street, State Housing, Calabar, Nigeria.

Introduction

Two quotations from two Forewords, written by two former Cross River State Governors /Chief Executives, in one book titled 'Whole system change of failing health systems', are excellent introductions to how Good Medical Practice contributes to a whole health sector and system transformation, using the homegrown 12-Pillar Clinical Governance Programme (12-PCGP).

In his own Foreword, former Governor, Mr Donald Duke, wrote, '--- having gone through two health commissioners already (since being elected to office in 1999), I invited Joe over for a chat. I was seeking something new, which I felt could be found in someone who had had the right exposure, not tainted by the inherent system, one who saw medicine as a calling and not an occupation'. And he added, '---------- Joseph Ana had, prior to his appointment in 2004 as health commissioner for cross river state, written several papers and memos on his random thoughts on the way forward for medicare in the developing world. However, one constant theme or refrain was 'Clinical Governance' which was new to me' (1). And in his own Foreword, for the same book, former Governor Liyel Imoke, wrote, '------- Dr Joseph Ana believes that while medical facilities and infrastructure may be desirable, the attitude and proficiency of the personnel is equally decisive in achieving good health care delivery for the people. And he added, 'the book therefore proffers an integrated, multi-sectoral, multidisciplinary and inter-professional plan of intervention which involves a whole system of best practices in health care.' (1).

This review article describes a significant successful development of a homegrown quality improvement tool, that is used to overcome failed efforts over decades to achieve better quality healthcare delivery in Nigeria, through good medical practice, and the substantial contribution of the 12-Pillar Clinical Governance Programme to the success. (5,6,7). It includes recommendations for a country-wide scale up of the programme to all the States and medical training institutions.

The philosophy underlying the 12-Pillar Clinical Governance model is that 'no matter how prestigious the buildings in hospitals and health centres, and no matter how sophisticated the equipment, the critical factors in preventing and reducing mortality and morbidity are the attitude and behaviour of the health workers, their knowledge, skills, and expertise'. Human beings use machines (including robots) to care for patients, and not the reverse'.

Both young and established health professionals in Nigeria, and other lower-, Low-, and Medium Income Countries (LLMICs) need to imbibe the knowledge and skills needed for the practice of clinical governance, just as their colleagues in the High-Income Countries (HICs) of the global North do. However, LLMICs suffer from 'Whole' Health Sector and System Failings, amidst the unique challenges of under-development and poor governance, which is different from the High-Income Countries. In HICs the health system failings are usually 'partial', because they always have in place the foundational pre-requisites for quality and safety in healthcare, that is, HICs always have functional physical infrastructure and good access to it, equipment, utilities (power, potable water, sanitation, security) and human resource in health (i.e. much better number / distribution, attitude, knowledge, skills and experience, welfare issues), hence the 7-Pillar version of Clinical Governance is suitable for them. On the other hand, LLMICs always lack these additional foundational top five pillars. It is impossible therefore to deliver a first-rate, patient-centered care in LLMICs using only the 7-pillar model, up-ending efforts to achieve Universal Health Coverage, reduce morbidity and mortality, and so on. In LLMICs, health practitioners are given the task to care for patients without appropriate tools or enabling environment, especially support and welfare. These shortcomings are compounded by the inadequate investment in the health sector as a whole, such that even in 2022, Nigeria is far from meeting the Abuja 2001 African Union Declaration on 15% of annual budget to be allocated for Health by African countries. In addition, capacity building and training is often the first to go from the list of priorities when there is need to cut costs and make savings, rationalize, or downsize. The Cross River State Ministry of Health (CRSMOH) in 2004 decided that the 7-Pillar Clinical Governance, started by Professor Sir Liam

Correspondence:
Prof Joseph Ana
Lead Senior Fellow/ Medical Consultant.
Centre for Clinical Governance Research & Patient Safety (ACCGR&PS) @ HRI Global. 8 Amaku Street, State Housing, Calabar, Nigeria.
Phone: +234 (0) 8063600642
Email: info@hri-global.org. Website: www.hri-global.org

Cite This Article As: Joseph Ana. 12-Pillar Clinical Governance and Good Medical Practice: transforming the whole health sector and system. Journal of Medical Standards & Ethics, 2023; Vol.1 (1): 12-18

Therefore, CRSMOH developed the 12-Pillar Clinical Governance Programme (12-PCGP) to fit Nigeria's context, as the solution for every facet of its Whole Health Sector and System failings, corporate and professional. The clear mission is that *Protecting Patients and Supporting Health Practitioners, shall be implemented in tandem*.

This home-grown model of clinical governance is defined simply as, an overarching framework for 'protecting patients and supporting the practitioners in tandem'. The success of the innovation is important as it demonstrates that institutionalising the doctor-led homegrown, scalable, 12-Pillar clinical governance programme (12-PCGP) leads to a whole health sector and system quality improvement in Nigeria, which is transferable to sister, similar lower-, low-, and middle-income countries (LLMICs). (1,2,3).

What Was Seen (During the Situation Analysis Visits)

The Cross River State Ministry of Health (CRSMOH) supported by maximum political will of the Governor-in-Council mapped out its approach as follows: needs assessment/situation analysis (SA); planning; building ownership / partnerships; state health plan (based on evidence from the SA; implementation, including resource mobilisation; and monitoring and evaluation. The situation analysis (SA) was the most comprehensive ever, conducted by a team comprising the Health Commissioner, Permanent Secretary and all directors in the ministry over a fourteen (14) day tour of all the fourteen functioning general hospitals; three special hospitals (Leprosy centre, Blind centre, and Orphanages); six uncompleted general hospitals; at least three primary health centres per each of the eighteen local government areas (LGA) in the State. In every site the inspection covered the whole facility from the entrance to the mortuary at the rear and every unit in-between. Data was gathered using the tools: facility assessment, provider views, user/patient views. The selected patients were chosen at random from those attending the facility on the day of the visit. The questions included how they felt about the care they received on previous attendance and on the day of the interviewer-administered survey. The shocking gaps and failings uncovered during the SA informed the preparation of the First State Health Plan. The Health Commissioner discovered from exchanging views with his colleagues during meetings including the National Council on Health that the situation was not better in other states of the country, which corroborates the chronic failure of all the efforts to transform the nation's health indices for decades. The shocking challenges: (1, 9,10,11,12).

The state of the health sector and system of the population of Cross River State in 2004 (like all other states in Nigeria), before the introduction of the 12-Pillar Clinical Governance Programme, was shocking and these were some of the challenges:

- lack of a strategic health vision, mission backed by law or anchored on a health in all policies policy (HiAPP)
- no formalized funding-mix (no mandatory health insurance)
- child mortality was 20% and maternal mortality was 1%.
- childhood routine immunisation rate was under 20%.
- there were only seventy-two (72) doctors with only one specialist (both clinical and non-clinical posts) for the 3.1 million population of the state. Some General hospitals had only one medical doctor.
- lack of patient centred care and copious complaints by dissatisfied patients / families about medical errors
- lack of the culture to update and maintain skills continuing professional development / continuing medical education (CPD/CME).
- lack of emergency ambulance service and inadequate skills in basic or advanced life support by health workers of all cadres
- lack of preparedness and inadequate response to Road Traffic and other accidents and Burns injuries.
- corruption was common including extorting patients.
- power cuts were ubiquitous/ unreliable including blackouts during surgical procedures, in intensive care units/neonatal intensive care unit (ICU/NICU) and labour wards during childbirth. No reliable power in the mortuary.
- potable water scarce/ lacking; waste and sanitation management appalling; bad attitude of health workers to patients was rampant.
- out-of-stock of drugs was the standard.
- HIV seroprevalence of 12%, the highest in the country.
- malaria as the greatest cause of death amongst children and pregnant women, and also the commonest cause of hospital visits and admissions
- increasing incidence of non-communicable disease such as Asthma, Diabetes, Hypertension, Cancer, Stroke, Coronary Heart Disease, mental illness (the 'silent killers').
- overworked, stressed, and demoralized health staff leading to lack of job satisfaction, low self-esteem, and increasing loss of personnel to the federal health service.
- inadequate health promotion activities
- lack of adherence to global best practice and poor oversight by statutory regulatory institutions for medical and health professions
- lack of consideration of the socio-economic determinants of health, including poor access to health facilities due to widespread extreme poverty, bad or lack of roads and transportation, and everything was a heavy struggle.

Chart: commonest patient / user complaints
(compiled from the patient/user survey reports in 2004, Situation Analysis).

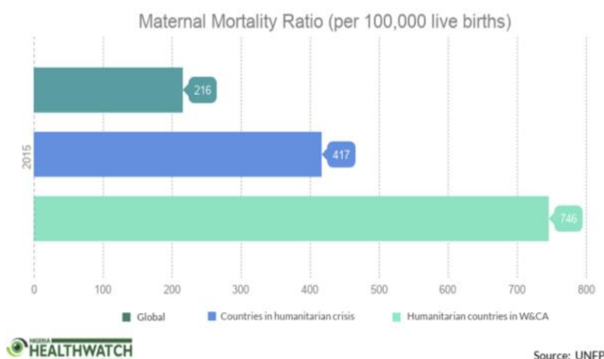
- Failure / delayed / wrong diagnosis
- Inadequate treatment / management
- Rudeness / bad attitude
- Failure / delayed home visit
- Failure / delayed referral
- Prescription errors
- Administrative problems e.g. 'no oxygen when needed'
- Inadequate / no physical examination
- Breach of patient confidentiality
- Removal from list without reason / explanation
- Communication problems
- Sexual abuse allegations
- Lack of patient informed consent
- others

The whole health sector and system failings cut across all the States in Nigeria, not only Cross River or Bauchi States.

Reports published by several bodies from the Federal Ministry of Health to development partners like the UNFPA and others show that the health indices across Nigeria, as shown in the graph below, continues to be disappointing, therefore this homegrown and validated quality improvement tool, the 12-PCGP which delivers Good Medical Practice in the unique context of the country, should be scaled to every state and the

Fig.1: The Homegrown 12 – Pillar Clinical Governance Programme 2004.

Federal Capital Territory and to all the preservice training institutions for health workers, from the training of medical students, student nurses and midwives, and others.



Bar Chart: Nigeria Demographic and Health Survey (NDHS) 2013 data

What was **d**one (after the situation analysis) was developing the Homegrown Contextual Solution for a whole health sector and system quality transformation, including:

Institutional Changes:
The State Ministry of Health, in 2004, set up the Centre for Clinical Governance, Research & Training (CCGR & T) that served as the Think-Tank for the innovative actions that followed. Later, the CCGR&T was upgraded to a full 'Department of Clinical Governance, Servicom and e-Health' in the Ministry**,** in 2007, to continue and sustain the work of implementing the 12-PCGP that had proved so successful and beneficial for patients, practitioners and the health sector and system of the State. (13,14,15).

Programmes recommended by the Centre for Clinical Governance, Research and Training (CCGR&T) include:

- Design and pilot the 12-Pillar Clinical Governance Programme, as overarching Quality Improvement tool.
- Integrate All Programmes. - Health in All Policies Policy (HiAPP). No Parallel or 'Stand-Alone' projects.
- Emergency Ambulance Care and paramedic service
- Integrate Primary Health Care (multidisciplinary with task shifting under guidance) e.g. Posting of NYSC doctors to primary health care.
- Set up Outreach Specialist Programme which attracted specialists from tertiary hospitals, the private sector and the retirement pool.
- Set up robust Welfare scheme: Reward(s) for performance in patient-centred care for all health workers. i.e. 'Putting Patients First, Always'. And Sanctions for repeated bad practice / behaviour.
- Set up Public-Private-Security initiative: for patients, staff, equipment and the facility.
  (Whole Facility security under the Risk Management Pillar)

Chart.1: List of Programmes recommended by the Centre for Clinical Governance, Research and Training (CCGR&T - Think Tank):
The State ministry of health decided that a suitable solution for the whole health sector and system failings found by the situation analysis, it had to design the 12-Pillar Clinical Governance Programme (12-PCGP) and pilot it, anchored on a Health in All Policies Policy, which was approved by the 'Governor-in-Council', and assisted by all the development partners within and outside of Cross River State. The idea came from the fact that the Health Commissioner had been a pioneer Clinical Governance Lead in the United Kingdom from1998 until 2004, when he returned to take up his post. The12-PCGP programme was supported by the Federal Ministry of Health and its parastatals, including the National Health Insurance Scheme – NHIS (now the National Insurance Authority-NHIA) and the National Primary Health Care Development Agency (NPHCDA) as it yielded its low-hanging fruit very quickly in a few months from the start of implementation. The programme was adopted by the National Council on Health (NCH) and the other States/FCT were encouraged to do the same as ~~in~~ Cross River State.

Training And Retraining on 12-PCGP (Postgraduate-in-service and Postgraduate-preservice).

It is imperative that the 12-PCGP is for all health care providers to partake in: the specialist and generalist doctor, dentist, nurse, midwifes, pharmacist, laboratory scientist., community health practitioner, dietitian, caterer, non-clinical staff including administrator, security, driver, porter, accountant, electrician, plumber, biomedical engineer, logistics practitioners, others. The 12-PCGP is multidisciplinary, multispecialty, and multisectoral, hence the outcome delivered is a whole health sector and system transformation.
The programme training applies at the point- of-care **in** hospitals and clinics, initially, but it should as well be introduced to the pre-basic training health institutions, so that future graduates of all cadres on attaining their basic qualifications are already introduced to the theory and practice of delivery of quality care (a.k.a. 'catching them young'). This should apply to medical schools / colleges as well as to the schools of nursing /midwifery, pharmacy, medical laboratory science, community

health practitioners, and so on. So far, the training has involved already graduated practitioners in practice, during their CPD / CME programmes, but the time is overdue to introduce 12-PCGP to the curriculum of these pre basic training institutions in Nigeria, as it is already the case in all high-income countries, like the UK, Europe, Australia, Canada, and America. The 12-PCGP training modules cover:

The Modules are:

- Health Management and Leadership including finance, infrastructure, utilities, etc
- Good Medical Practice & Patient centered care
- Research and Audi**t** in Health Practice and
- Health Information, ICT and Use

HM – Leadership in Health and Hospital Management

- 12- Pillar Clinical Governance Programme
- Leadership and human resource management in health
- Risk Assessment and Quality Assurance in health
- Quality Frameworks & Standard Operating Procedures
- Project planning and management including Monitoring and Evaluation
- Healthcare Economics and Financing
- Health infrastructure, Utility & ambience
- IT skills acquisition and application in Health

CG–Good Medical Practice (The doctor/patient relationship)

- 12 Pillar Clinical Governance programme
- Ethics, Jurisprudence, carriage in practice, including duty of care.
- informed consent, confidentiality, and health records (electronic and paper records)
- practice and personal development plan (PUN & PEN, Audit cycle) (PUN-Patient Unmet Needs; PEN=Practitioner educational needs)
- Consultation skills: PUN and PEN
- Rational drug prescribing and use, including local formulary.
- Rational investigation and pathology services
- Clinical Skills Acquisition (e.g., Basic Life Support/CPR; Advanced Trauma Life Support, Minor surgery, etc)
- Basic direct care, including dressings and appliances (Plaster of Paris, etc)
- Communication and Health Promotion skills.
- Patient centered care, including patient awareness and participation.
- I.T. skills acquisition and application mandatory for selected cadres.

RS – **Research in Health Practice, ICT and Use**

- 12-Pillar Clinical Governance programme
- How to read, write, get published including Open Access
- Original research methodology skills and types including biomedical statistics.
- Clinical research methodology skills including BIOMEDICAL statistics.
- Critical appraisal of research papers and application of results
- Clinical AUDIT and implementation
- Accessing Research Resources including Grants
- Ethics of Research and Publication Misconduct
- Presentation skills and conferencing
- I.T. skills acquisition and application in health- Telehealth, eHealth, mHealth, social media in Health
- AI – Artificial Intelligence, Robotics in Health
- others

Chart 2: List of the 12-PCGP Training Modules and Topic Breakdown.

The Ministry of Health after several consultations and training workshops, developed a Patient Centred Care mandate for all staff, as part of the Good Medical Practice initiative under the 12-Pillar Clinical Governance Programme (12-PCGP):

Good Medical Practice and Patient Centred Care

This aims to put patients_'first' and guarantee patient satisfaction, improve patient outcome across all disease areas by all staff working as a team, that:

- reduced OPD waiting times.
- prevented queue jumping and promote equity.
- improved patient/ public orientation and awareness
- ensured patient know where and how to access service/ units of the hospital.
- ensured patient know where and how to complain of poor service and get redress.
- improved staff identification and privacy.
- improved patient comfort throughout their stay in the facility.
- improved patient amenities in all parts of the facility.
- introduced triage by trained triage nurses / other cadres.
- applied up-to-date Consultation skills for all cases (History, Examination, (test), Treat and follow up / refer, as applicable. Sustain being up to date, by Lifelong Learning!
- improved organisation of patient records / introduce electronic held records system.
- communicated with patient / family better (e.g., why the wait / why the delay).
- explained delays and provide side useful attractions as they wait (e.g., health promotion videos).
- established an appointment system starting with the flagship Calabar General hospital.

- monitored and audited the system / processes regularly at the Inspections Unit.

Clinical Governance Applies to Public as Well as Private Health Care

Chart 3: Good Medical Practice Clinicians Duties under the 12-PCGP (CCGRT, 2004)

PHOTO 1 (a & b): International Endoscopy Workshop (OBY/GYN, Surgery), General Hospital Calabar in 2006

What was Achieved (Through Implementing The 12-PCGP) was the whole health sector and system improvement. The 12-Pillar Clinical Governance programme continues to deliver the whole health sector and system transformation, that was reported in the pilot report in 2008, wherever it is implemented in Nigeria, the States or Private hospitals. This positive results in this article demonstrates that it is time to introduce the training modules on clinical governance, across the nation, to medical schools and to other institutions of training of the other health workers (nurses, midwives, pharmacists, medical laboratory scientists, physiotherapists, community health practitioners, and all others. In 2006 and 2007 the National Council on Health adopted the memorandum from the Cross Rover Ministry of Health on the 12-Pillar Clinical Governance Programme and the verifiable results that it was yielding. Six Ministers of health since then have declared during their tenures that 'Nigeria needs Clinical Governance'. In 2012 the Nigerian Medical Association (NMA) on seeing the benefits to Good Medical Practice of its members, in hospitals where it was implemented, adopted the 12-PCGP and established its Ad Hoc Committee, which has been upgraded to the NMA Standing Committee on Clinical Governance. (17).

The following expected and desired whole health sector and system positive results were achieved within three years of the integration of the 12-Pillar Clinical Governance Programme:

- Increase in the number of health workers, especially doctors, nurses, pharmacists and other skilled professionals, including attracting able retirees to come back to service.
- Positive change of staff attitude to patients, and in updating their knowledge and skills regularly.
- Adoption of making evidence-informed health policy backed by Law, anchored on a health in all policies policy (HiAPP).
- Implementation of a robust, sustainable funding-mix, including a mandatory health insurance scheme. (the first and second of the 37 States /FCT!)
- Renovation and maintenance of the physical infrastructure and access roads.
- Installation of appropriate equipment; installation of 24/7 potable water and electricity (from generators and solar power); ensuring security and clean hospital environment.
- Creation of a fourteen vehicle, 24/7 Emergency Ambulance and Paramedic service, including giving access to Traditional Birth Attendants and Civil Society Organisations to call ambulances for referred patients.
- Creation of a new Department of Clinical Governance, Servicom and e-Health, with line budget in the Ministry of Health, for future sustainability.
- Adoption of a multi-sectoral Integration of all Programmes, thereby abolishing parallel or 'stand-alone' projects favoured by donor partners.
- Establishment of Minimal Access Treatment at the state-owned General Hospital, Calabar, with full Endoscopic procedures in 2006.
- Providing improved Welfare for staff including a 'rewards for good performance' scheme, and 'Putting Patients First, Always' and sanctions for repeated bad practice/behaviour).
- Established a targeted Public Private Partnership (e.g. 'drug revolving fund', catering services, sanitation, mortuary)
- Provided enhanced Security initiative: for patients, staff equipment and buildings (for the whole facility, men and machines).
- Achieved an evidence-driven, empathy-driven administration of the health sector and system; and Significantly, increased the combined domestic and partner funds for health (from about N438 Million annual budget in 2003/4 to about N5.8 Billion for the 2007/8 budget for CRSMOH). This increased investment led to the Clinical Practice Allowance (CPA) that meant that State employed health workers earned the same as their colleagues in the Federal Government-owned Teaching Hospital, which reversed the 'internal Brain Drain'.
- Increased patient attendance, patient satisfaction and adherence and compliance to medical advice and treatment. (from regular patient-user surveys)
- Increased Ante Natal Care attendance and childbirth by skilled health workers in formal primary health care workers and hospitals.
- Achieved Public Health Legislations e.g., compulsory seatbelts in cars and helmets by motorcyclist Law which led to reduced mortality from Road Traffic Accidents.
- Increased Routine Immunisation Coverage from less than 20% to 84% over three years; eliminated wild polio virus over three years, and
- Reduced HIV seroprevalence rate from 12% to 6.1% in three years.
- Several thousands of pregnant women and children under 5 received and used ITNs (insecticide-treated nets);
- Achieved the lifting of the embargo on recruitment and in-service training for health workers, both local and overseas.
- Established mandatory paid-continuing professional development /continuing medical education (CPD/CME) workshops, covering the 12-Pillars, for all cadres of health

workers assisted by Development Partners, which improved recruitment, and retention of health professionals.

- Cross River State Health received multiple national and international Awards for excellent performance anchored by the 12-PCGP.

(CCGRT, SMOH, CALABAR, NIGERIA 2004)
(Ana, J. 'Whole system change of failing health systems' 2009)

Chart 3: List of impactful results due the introduction of Good Medical Practice using the 12-Pillar Clinical Governance Programme.

Other benefits of 'protecting patients and supporting practitioners in tandem' using the 12-PCGP. More results of introducing good medical practice using the 12-pillar clinical governance programme:

'Protecting Patients'	**'Supporting Care-Providers'**
- Fast service to patients	- Attitude & behaviour change
- Efficient service	- Continuing Prof. Development
- Responsive	- Life-long learning
- High quality	- Training and retraining
- Consistent	- Welfare including Pay.
- Equity	- MDCN compliant practice
- Satisfied patient	- Job satisfaction

(CCGRT, SMOH, CALABAR, NIGERIA 2004)
(Ana, J. 'Whole system change of failing health systems' 2009)

Chart 4: List of more results due to the introduction of Good Medical Practice using the 12-Pillar Clinical Governance Programme

Photo 2 (a &b): Two former ministers of health delivering Awards to Cross River State Ministry of Health (2006, and 2007, respectively) for developing a patient Safety culture and Good Medical Practice **using** the 12-PCGP.

LIMITATIONS

The lack of continuity and loss of Political Will in Nigeria for inherited programmes, by succeeding administrations, affected the progress of the 12-Pillar Clinical Governance Programme in both Cross River and Bauchi States, after change of elected Governments in 2008 and 2015, respectively. The interruption of the implementation also meant that gathering of data to report on medium- and long-term outcomes, such as mortality reductions in maternal and childcare, for example, which need longitudinal accumulation of data, stopped. However, in Cross River State, at least, the programme survived those years of hibernation (during 2008-2020), because of the foresight in the creation of a 'Department of Clinical Governance, Servicom and e-health' with its substantial budget line in 2007. In addition, the Reactivation of Clinical Governance in Cross River State, from 2020, following the strong recommendation of the health workers to the Commissioner for Health, Dr Betta Edu, is replicating all the impactful results in Charts 3 and 4, again. (18).

The way forward and recommendations:

There is need for scalability of the 12-PCGP to all States/FCT and private hospitals in Nigeria. For sustainability in Cross River State, a brand new 'department of Clinical Governance, Servicom, and e-Health' was established in 2007. The quality tool was welcomed, replicated and adopted by the Bauchi State Government (2008-2015), and the State was constructing an 'Malam Isa Yuguda Institute of Clinical Governance' in 2014, under guardianship of Prof Baba M. Gana as the Adviser on Health to The Governor. The 12-Pillar Clinical Governance Programme was introduced to private hospitals, including the Calabar Women and Children Hospital, Calabar (2009), Lily Hospitals Ltd Warri and Benin City (2011), and Capitol Hill Clinic Warri (2013), in Delta and Edo States. These clinically governed hospitals have achieved independent Quality Accreditation, ISO 9001, and Lily Hospital, in addition, has achieved COHSASA Accreditation (Council for Health Service Accreditation of Southern Africa), from South Africa. These positive changes were replicated in Bauchi State in 2008-2015. The private hospitals have also concurred the achievements in performance, quality, and safe care for their patients as captured above.

Scalability to other lower-, low-, and middle-income countries (LLMICs) with similar health sector and system weakness and challenges:

From the experience of successfully scaling up the 12-Pillar Clinical Governance Programme to States and private health facilities in Nigeria, it is safe to believe that this approach to clinical governance is transferable to other low-income countries with similar health sector and system challenges. But it must be stated that merely introducing clinical governance will not automatically cure all the ills and challenges that beset a country's weak health sector and system, without the **P**olitical **W**ill and commitment to sustain the programme for the long term. To start and stop as soon as the first positive results appear, before a culture of quality and safety is entrenched, shall guarantee failure and wasteful return to the status quo, whether in public-owned or private health facilities, as the Cross River State experience has demonstrated.

CONCLUSION

The success of the homegrown, evidence informed 12-Pillar Clinical Governance Programme in embedding Good Medical Practice and achieving several quality indicators, in an LLMIC country like Nigeria, with its unique development-related, decades-long failings of the health sector and system, in spite of continued investment (even though usually inadequate investment), demonstrates the value of context and the location when designing a health improvement plan and programme. Sustained Political Will and avoiding policy flip-flops with every change of government, are two of the critical elements

needed to build a resilient clinically governed programme that 'protects patients and supports practitioners in tandem'. (16).

References:

1. Ana, JNE. Whole system changes of failing health systems. (Experience of 4-year pilot of Clinical Governance, Quality & Safety in Cross River State, Nigeria. 2009. ISBN: 978-978-49487-0-8. pp 185.
2. Smith, R. *'How to rebuild global health*: Joseph Ana's book describes how he turned around the failing health system in a southern Nigerian state. *BMJ 2010; 341:c5520 doi: 10.1136/bmj.c5520*
3. **Trivedi, B. '**Is impressed, *INSPIRING LIVES'* - Joseph Ana - Health Commissioner on a Mission. *"He made healthcare accessible to everyone in the state*', In: Scientific American (fall-June, 2010):
4. Sally G, Donaldson LJ. Clinical Governance and the drive for quality improvement in the new NHS in England. BMJ 1998; 317: 61–5.
5. Ana JNE. Clinical Research Demystified. Pocket handbook for doctors, nurses and other health practitioners (including a chapter on modern consultation skills). 2009. ISBN: 978-978-49487-3-9. p 72.
6. Cross River State of Nigeria First State Health Plan 2004–2007. Approved by Governor-in-council: Calabar. 2004.
7. Memorandum of the Honorable Minister of Health on the 2006–2010 strategic plan for strengthening routine immunization. Jalingo, Taraba state, Nigeria, 2006.
8. Keynote address by Honorable commissioner for health, Cross River State First Primary Health Care Stakeholders Conference, Calabar. 2006.
9. Ana JNE, Bassey, J. A. Handbook on Clinical Governance, Research and Training. Vol. 1; Centre for Clinical Governance, Research and Training, Ministry of Health, Calabar, Nigeria: 2006.
10. Patient's Rights and Responsibilities. Centre for Clinical Governance, Research and Training, Ministry of Health, Calabar, Nigeria. 2006.
11. Patient Fee Card (promoting patients right to information). Centre for Clinical Governance, Research and Training, Ministry of Health, Calabar, Nigeria. 2006.
12. Essential Drugs Formulary. First Edition, Centre for Clinical Governance, Research and Training, Ministry of Health, Calabar, Nigeria: 2005.
13. Emergency Ambulance mobile phone numbers for the eleven ambulances in the fleet (promoting public right to emergency ambulance service); Centre for Clinical Governance, Research and Training, Ministry of Health, 2005. Calabar.
14. Communique: 30th Annual General Meeting of the West African College of Physicians (Nigerian Chapter); Maiduguri, Borno state, 20th – 23rd July, 2005.
15. Ana, J. 'compilation of expert commentaries and editorials on clinical governance, research and training in West Africa' 2006. Lagos. Fine print
16. Cross River State of Nigeria Second State Health Plan 2007–2011; (MTSS / MTEF). Approved by Governor-in-Council: 2007. Calabar.
17. Ana, J. Clinical governance in Nigerian hospitals: Nigerian Medical Association leads. http://africa-health.com/wp-content/uploads/2015/10/Africa-Health-Nigeria-January-2014-compressed.pdf. 2014.
18. Centre for Clinical Governance Research & Patient Safety @ HRI Global (www.hri-global.org). Final report of the Reactivation of Clinical Governance in Cross River State General Hospitals (Calabar, Ugep, Obubra, and Ogoja) from July 2020 to March 2022. Calabar. August, 2022. (IN PRESS).

Professor Joseph Ana *BM BCh (UNN), DFFP-UK, DUrology-UK, FRCSEd, Jt,Cert.RCGP-UK, CertClinGov UK, was the Honorable Commissioner for Health, Cross River State, Nigeria 2004-8, and led the introduction of clinical governance to Nigeria*. He is Secretary General/Trustee of the Nigerian Medical Forum (NMF) and was Managing Editor of BMJ West Africa local edition from 1995-2018. He is currently the Lead Senior Fellow / Medical Consultant, Centre for Clinical Governance Research and Patient Safety @ HRI Global, Calabar, Nigeria. www.hri-global.org