

A Framework for Surgical Clinical Governance

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Foreword	4
Introduction	5
Members of Expert Consultative Group	6
Introduction and Context	7
A Framework for Clinical Governance in Surgery	8
Executive Summary	10
DOMAIN 1 – Multidisciplinary Team (MDT) Meetings	13
Principles of Effective Surgical MDT Meetings	13
Recommended Procedures for Effective Surgical MDT Meetings	14
DOMAIN 2 – Mortality and Morbidity (M&M) Meetings	16
The Importance of M&M Meetings in Surgical Governance	16
Principles for Effective M&M Meetings	16
DOMAIN 3 – Patient Safety, Risk Management and Clinical Audit	18
Patient Safety and Risk Management	18
Essential Patient Safety Protocols	19
Clinical Audit	19
Patient Safety - Training and Education Programmes	21
DOMAIN 4 – Practice Innovation, Research and New Technologies	25
Principles for Governance of Innovation and New Technologies	25
Introducing New Surgical Practices or Technologies – Required Process	26
Implementation Roadmap for Surgical Clinical Governance Framework	27
Phase 1: Establishing Governance Foundations	28
Phase 2: Standardising Core Governance Processes	28
Phase 3: Embedding Learning, Accountability and Continuous Improvement	29
Surgical Governance Maturity Model	30
Level 1: Governance Foundations	30
Level 2: Emerging Structured Governance	31
Level 3: Established and Integrated Governance	31
Level 4: Exemplar Learning and Improvement Culture	31
References	34
Appendices	35
1. Morbidity and Mortality (M&M) Meeting Template	36
2. Surgical MDT & M&M Minimum Dataset Templates	37

Foreword

Professor Deborah McNamara, RCSI President



Surgeons are privileged to care for people at some of the most vulnerable moments in their lives. With that privilege comes a profound responsibility—to deliver the highest standards of care, to learn from our experiences, and to be transparent about the challenges we face. The trust the public places in us is earned daily, and it must never be taken for granted.

Surgical practice is defined by complexity. Our decisions often involve competing risks, limited resources, and the need to act quickly while supporting patients through uncertainty. The quality of our communication, the reliability of our systems, and the clarity of our clinical governance structures all shape the outcomes patients experience. When these elements work well, safety is strengthened. When they do not, the consequences are felt by patients, families, and frontline staff.

Risk management is not theoretical in surgery—it is embedded in the rhythm of our working lives. Structures such as Morbidity and Mortality (M&M) conferences, Multidisciplinary Team (MDT) meetings, and other shared decision-making forums remain essential pillars of safe practice. Yet our engagement with surgeons across the country reinforced a reality that many already know: access to the supports required to ensure high quality care is inconsistent. Protected time is not always guaranteed. Escalation pathways and the responsiveness of governance systems to identified risks vary between hospitals. And innovations can take too long to evaluate and implement.

This framework document acknowledges the pressures facing our health service, including increasing demand, workforce shortages, and capacity constraints. These challenges are real and cannot be solved by clinicians alone. However, meaningful improvement is achievable. Throughout our consultation, we encountered surgeons and teams delivering exemplary practice despite system strain—evidence of what is possible when governance structures are clear, leadership is engaged, and collaboration is prioritised.

A recurring theme in our discussions was the need to strengthen the connection between clinical governance and organisational governance. Surgical teams cannot carry the full weight of daily safety oversight without active partnership from clinical directors, hospital management, and the wider health service. High reliability systems depend on timely responses to identified risks, consistent accountability, and a culture in which concerns can be raised early and acted upon. When these conditions are present, good practice becomes the norm rather than the exception.

This report is RCSI's constructive contribution to the national effort to improve patient safety and support our surgical workforce. It builds on the insights of surgeons working across diverse specialties and hospitals, and on the experiences they shared candidly—of systems that work well, and systems that need urgent attention. Their honesty and expertise have shaped the recommendations contained here.

I am deeply grateful to the RCSI Expert Group on Best Practice in Clinical Governance in Surgery, convened in June 2024 and chaired by Council Member Mr David Moore (FRCSI). I also extend my thanks to all stakeholders who participated in the consultation, and to the Department of Surgical Affairs—particularly Kieran Ryan and Daniel Howard—for their leadership and commitment throughout this process.

The issues explored in this report matter deeply. They speak to the safety, quality, and consistency of the care we provide, and to the confidence our patients place in us. Strengthening surgical governance is both a professional obligation and a societal one. I am confident that the framework presented here will help us meet that obligation and support a safer, more reliable health service for all.

Professor Deborah McNamara

President, Royal College of Surgeons of Ireland

Introduction

Mr David Moore, Chair of Expert Group on Best Practice in Clinical Governance in Surgery



RCSI's Framework for Surgical Clinical Governance sets out the standards, structures, processes, and responsibilities required to support excellence in surgical practice in Ireland. It brings together key components of surgical governance including leadership and accountability, clinical effectiveness and quality improvement, risk management and patient safety, and education and training. Through the integration of these elements, the Framework aims to foster a culture of openness, learning, and shared responsibility across Irish surgical practice.

Effective clinical governance in surgery is essential in managing the inherent complexity and risk associated with the ever-evolving nature of surgical care. This Framework supports surgeons, multidisciplinary teams, hospital management and directors, to identify and mitigate risk, learn from adverse events, use evidence-based practice, and monitor outcomes to drive improvement. It also reinforces the importance of professional standards, ethical practice, and compliance with national policies, regulatory requirements, and best practice guidelines.

By setting out clear governance structures and operational expectations, this Framework enables Irish healthcare organisations assure their quality of surgical provision, support clinical teams in delivering safe and effective care, and demonstrate accountability to patients, staff, and the wider healthcare system. Its consistent application will strengthen service resilience, improve patient outcomes and experiences, and support sustainable, high performing surgical services in Ireland.

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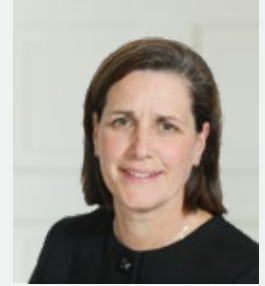
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Introduction and Context

Clinical governance in surgery is a structured framework through which surgical departments and healthcare organisations maintain and continuously improve patient safety, clinical effectiveness, and professional accountability. At its core, clinical governance integrates essential elements such as leadership and accountability, clinical audit, risk management, patient involvement, ethical oversight, workforce development, and professional competency.

The primary aim of surgical clinical governance is to deliver safe, high-quality, patient-centred surgical care consistently and reliably.

The importance of robust clinical governance in surgery cannot be overstated. Effective governance structures ensure that surgical practices adhere to established safety protocols and evidence-based guidelines, thereby reducing adverse events and improving patient outcomes. Moreover, it fosters a culture of transparency and learning, which is vital for continuous improvement and trust-building among patients, surgical teams, and the wider healthcare community. Strong governance also supports the professional development of surgeons and other surgical care team members, addressing workforce challenges and ensuring sustainable high standards of practice.

This Surgical Clinical Governance framework aligns closely with the Health Service Executive (HSE) Clinical Governance Framework¹, which emphasises clear accountability, defined authority levels, patient safety, risk control, interdisciplinary collaboration, and continuous quality improvement. This alignment ensures a unified and consistent approach to delivering safe and effective surgical care across the Irish healthcare system, with specific measures such as the internationally accepted WHO Safe Surgery Checklist² and the HSE incident management frameworks³ reinforcing these standards.

This Framework for Clinical Governance in Surgery reflects international guidance as outlined by frameworks such as the Royal College of Surgeons of England's (RCS England) "Good Surgical Practice"⁴ and the Royal Australasian College of Surgeons (RACS Australia) Clinical Governance Framework⁵. RCSI has also produced an updated Code of Practice for Surgeons⁶ which outlines the professional standards to support our fellows and members in their day-to-day roles. These frameworks provide comprehensive guidelines and standards for maintaining quality, safety, accountability, and continuous improvement in surgical practice. By benchmarking against these international standards, Irish surgical governance structures can ensure global best practices are incorporated, positioning quality and safety at the forefront of Ireland's surgical care.

In summary, effective clinical governance in Irish surgery is critical for ensuring patient safety, clinical excellence, and professional accountability. This RCSI Framework for Surgical Clinical Governance is aligned with both national HSE guidelines and international frameworks, thereby establishing a robust, consistent foundation that promotes continual improvement and exceptional patient care.

A Framework for Clinical Governance in Surgery

Purpose The core purpose of the framework is to establish clear guidelines, structures and responsibilities that promote patient safety and improve surgical outcomes. It supports the systematic identification, management, and mitigation of risks; fosters a culture of transparency and open communication; and promotes ongoing education and professional development.

Scope This governance framework can apply to all surgical departments within hospitals in Ireland, whether it is in the Government Funded, Voluntary Sector or Independent Sectors. It covers a wide array of surgical practices, ranging from routine scheduled elective surgeries to complex unscheduled emergency procedures. The framework encompasses several critical domains.

Objectives *The objectives of the Framework for Clinical Governance in Surgery are to:*

- Ensure patient safety through rigorous adherence to evidence-based surgical guidelines and practices.
- Foster accountability and clarity in clinical and managerial roles within surgical departments.
- Promote continuous quality improvement through structured clinical audits and outcome analysis.
- Support robust incident reporting systems that facilitate learning from errors and near misses.
- Establish comprehensive evaluation and approval processes which foster innovation and research in surgical practice and technologies.
- Enhance communication, transparency, and trust among patients, healthcare providers, and stakeholders.
- Provide comprehensive, ongoing professional development and training for all surgical personnel.
- Guide the implementation of clear mechanisms for monitoring, evaluating, and refining governance practices regularly.

Intended Users

The framework is intended for use by:

- Surgeons and Surgical Trainees, to guide clinical practice and professional responsibilities.
- Regional Clinical Directors, Regional Clinical Leads, Clinical Directors and Perioperative Clinical Directors, for overseeing and ensuring compliance with governance standards.
- Hospital and healthcare system leadership, to implement policies and practices that support surgical governance.
- Healthcare policymakers and regulatory bodies, to inform policy development and ensure alignment with national and international healthcare standards.
- Members of surgical and perioperative teams, including nurses, anaesthesiologists, and support staff, to ensure collaborative and coordinated care delivery.
- By clearly defining the purpose, scope, objectives, and intended users, the Surgical Clinical Governance Framework serves as a critical tool for ensuring excellence in surgical care, improving patient outcomes, and supporting a culture of continual learning and professional accountability.

**THE FRAMEWORK FOR CLINICAL GOVERNANCE IN SURGERY
WILL BE BASED ON 4 DOMAINS**



Executive Summary

Clinical leadership, with well-defined and supported roles, is essential for effective clinical governance in surgery and delivery of safe surgical care. From our National Survey of Fellows and Members in Ireland⁷, we found that there was a wide variety of leadership roles held by surgeons. RCSI is aware that the HSE and other service providers develop their own roles and structures to support clinical governance.

Such clinical leadership roles require the necessary resources, protected time, administrative support and access to expertise in order to discharge their duties accordingly. This framework is a supportive guide for any surgeon taking on such clinical governance leadership roles.

Surgical Governance Accountability



To have effective Clinical Governance in Surgery, our expert group have identified **4 ESSENTIAL DOMAINS**:



DOMAIN 1: Multidisciplinary Team (MDT) Meetings

- Weekly or bi-weekly meetings focused on complex patient management and pre-operative planning. Structured in accordance with the service needs or standards.
- Ensures coordinated care decisions, informed by multi-specialty collaboration.
- Ensures awareness and discussions around novel or innovative practices or technologies.
- Facilitates shared decision-making and consensus on patient care pathways.
- There should be a defined process for the establishment, running and resourcing of MDT meetings by the Healthcare Provider.
- Participation in the relevant MDT meeting is required by all Surgeons and Surgical Specialties.
- Inclusion of post-operative assessment as appropriate.
- Presentation and discussion of relevant KPIs (e.g. NCCP KPIs).
- Must be seen as a normal part of clinical service delivery in the interest of patient safety and resourced adequately.



DOMAIN 2: Morbidity and Mortality (M&M) Meetings

- Meetings should be held regularly, for example monthly or bi-monthly.
- There should be a defined process for M&M meetings defined by the healthcare provider.
- Clinical data presented should be co-created with the relevant expertise (e.g. Data Evaluation Panel).
- Confidentially reviews patient cases resulting in significant and unexpected complications or deaths.
- Confidentially discusses adverse outcomes in a multidisciplinary, non-blame environment to identify learnings and systemic improvements.
- Participation in the defined M&M process is required for all surgeons and surgical specialties.
- There exists a defined and appropriate reporting or escalation structure within the healthcare provider.
- Adherence to legislative requirements for Patient Safety Act 2023 (Notifiable Incidents and Open Disclosure).



DOMAIN 3: Risk Management and Clinical Audit

RISK MANAGEMENT

- Clear and accessible incident reporting systems aligned with the HSE Incident Management Framework (Health Service Executive, 2020).
- Incident reviews conducted transparently, following clear guidelines on open disclosure.
- Learning from incidents systematically integrated into clinical governance meetings, with clear feedback loops and accountability for implementing changes.

CLINICAL AUDITS

- Conducted regularly, with active participation from all surgical specialties and staff.
- Reviews adherence to relevant clinical standards and published best practices.
- Regular reporting of key surgical safety key performance indicators (KPIs) or metrics to be used and benchmarked, such as, but not limited to, Surgical Site Infection (SSI), Unplanned Returns to Theatre
- Utilises audit results to drive quality improvements, supported by adequate IT infrastructure for effective data tracking.



DOMAIN 4: Practice Innovation, Research and New Technologies

- Surgical practice is evolving at a rapid pace. All surgical care should be provided based on the published evidence and standards.
- Research is essential for the development of surgical care and all research governance standards should be implemented. This includes structures such as research ethics committees, research consent processes, data protection and documented agreements between all parties.
- New technologies are being introduced at an extraordinary pace. Appropriate governance allowing for the introduction, testing, and monitoring of new technologies should be in place. The RCSI document for '[Robotic Surgery Governance in Ireland: A Guide to Good Practice](#)' provides guidance on the implementation of a robotic surgery programme.

Access to dedicated education and training programmes and structured induction for clinical governance and leadership skills should be supported for individuals with responsibility and accountability for clinical governance in surgery. RCSI provides courses in Clinical Leadership, Management, Human Factors in Patient Safety, Professionalism in Medicine and Health Sciences. All Surgeons and Surgical Trainees should be encouraged and supported to participate in training, education and CPD relating to surgical clinical governance and related matters. (See [RCSI CPD Scheme](#))

Hospital governing bodies and management should provide protected time to allow staff engagement with essential governance and quality improvement activities as outlined in this Framework Guidance.

DOMAIN 1: Multidisciplinary Team (MDT) Meetings



Multidisciplinary collaboration is identified as best practice for ethical oversight and patient-centred care. The absence of robust MDT processes was highlighted as a critical gap in the HIQA CHI Temple Street review⁸, which significantly impacted patient safety and governance effectiveness. Effective MDT structures ensure comprehensive clinical and ethical reviews, fostering informed decision-making and reducing risks associated with clinical procedures.

Surgical MDT meetings are not a new concept. However, the approach to MDTs varies greatly across Irish surgical departments. In some cases, such as certain cancer protocols, the best practice guidance requires a MDT to recommend treatment strategies⁹. In other treatment areas there are no specific guidance on MDTs. It is recommended by RCSI that all surgical departments would adopt a clear policy with respect to MDTs which should be approved and monitored by the assigned surgical governance lead. In smaller specialties or in the treatment of rare conditions, consideration of establishing regional or national MDTs is recommended. It is also recommended that hospital leadership ensures that MDTs are properly resourced and have the necessary protected time as part of their service delivery.

The principles and procedures required to have an effective surgical MDT meeting process, drawn from a synthesis of best practices outlined in governance and clinical management documents, include the following:

Principles of Effective Surgical MDT Meetings

- The meetings should have a patient-centred focus.
- Decisions should be based on individual patient needs and preferences, reflecting the patient perspectives wherever appropriate.
- Ensure a commitment to patient safety, dignity, and informed consent, ensuring patients understand risks, benefits, and alternatives to surgical interventions.
- Identify clear accountability and governance.
- Defined leadership roles, with explicit responsibilities and accountability structures within the MDT for decision-making and follow-up actions.
- Oversight by a Clinical Director or senior clinician with clear authority to manage clinical governance activities.
- Active collaboration across all relevant specialties (e.g., surgery, medicine, anaesthesiology, nursing, pathology, radiology) to ensure holistic patient assessment and management.

- Encouragement of mutual respect and open communication within the team to foster effective interdisciplinary working.
- Foster a culture of openness and transparency. Open and transparent communication regarding clinical outcomes, complications, or adverse events to promote collective learning.
- Promotion of a blame-free culture where team members are encouraged to speak openly, especially regarding errors or near misses.
- Use of evidence-based guidelines, national and international standards, and current research to inform clinical decision-making and treatment recommendations.
- Regular integration of clinical audit outcomes into MDT discussions to drive continuous improvement.
- Regular review and monitoring of MDT processes, effectiveness, and clinical outcomes against agreed Key Performance Indicators (KPIs).
- Implementing learning from morbidity and mortality meetings and clinical incident reporting into routine MDT operations.
- Use of structured documentation and consistent methods for presenting and discussing patient cases, ensuring clarity and completeness.
- Defined protocols for escalating concerns or disagreements within the MDT.

Recommended Procedures for Effective Surgical MDT Meetings

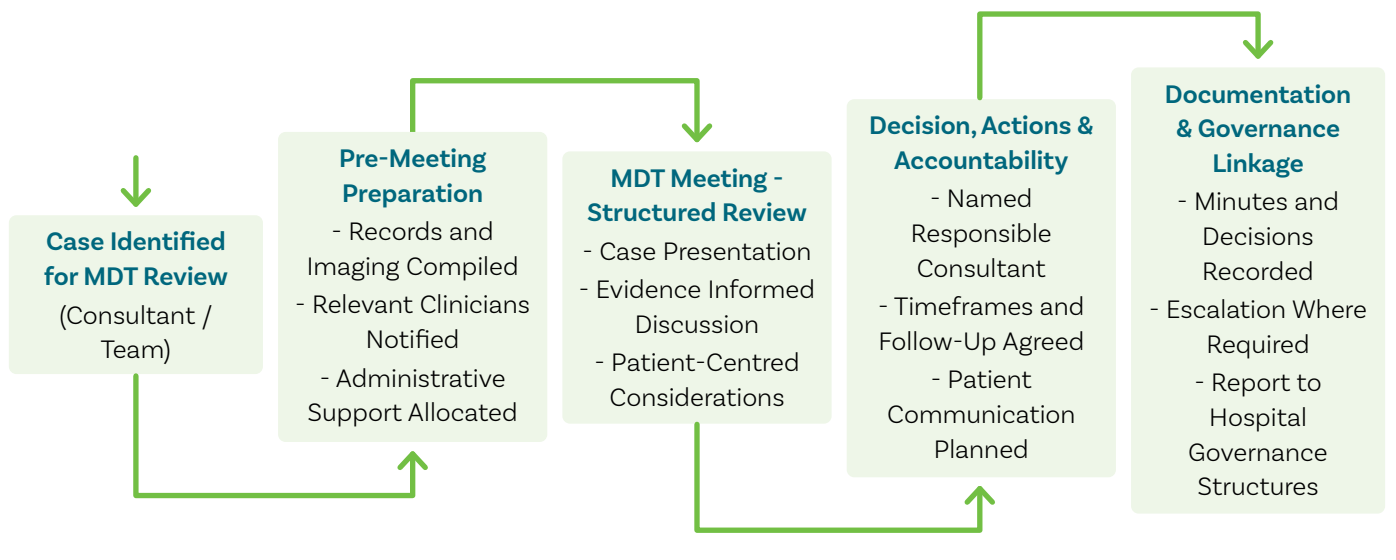
- There is a process for the selection of cases for inclusion at MDT meetings (*NHS England, 2019*).
- There is a policy on the nature and types of cases which must be presented at a MDT. This may include a relevant scoring system based on agreed clinical parameters depending on the disease area or specialty.
- There is a policy mandating that the treating surgeon must attend (in-person/virtually) the MDT where their cases are required to be presented at the MDT meeting.
- There is well resourced meeting preparation and coordination. This should not only include administrative resources, but appropriate room, IT access and other physical resources and remote or hybrid access.
- There is clear scheduling and regular frequency (e.g., weekly or monthly meetings), with sufficient administrative support to manage patient lists, records, and documentation.
- There is advance distribution of patient information and related documentation to all participants.
- There is a defined methodology for structured case presentation. Standardised format for presenting patient cases including clinical history, investigations, diagnosis, proposed treatments, and potential alternatives or risks.
- There is comprehensive multidisciplinary review.
- There is inclusion of all relevant clinical disciplines in each meeting to discuss cases thoroughly, allowing comprehensive risk assessment and decision-making.
- Use of systematic grading and documentation to capture and evaluate discussions and decisions.
- There is clear documentation of decisions taken, including rationale, responsibilities for follow-up actions, and timelines for implementation.
- There is communication of outcomes to patients ensuring they understand the treatment plans agreed by the MDT.
- There is effective follow-up and accountability.
- Responsibility is assigned for agreed actions and ensuring there is a robust follow-up mechanism

to monitor implementation and outcomes.

- There is regular feedback on outcomes of decisions back to the MDT for review and continuous learning.
- There are clear protocols for reporting adverse events or near misses arising from MDT decisions, integrating these into broader incident management and clinical governance frameworks. Immediate action and analysis when safety or procedural issues are identified, followed by clear dissemination of learning.
- There is access to regular training and professional development for MDT members in clinical governance principles, ethical practice, team communication skills, and latest clinical evidence.
- There is structured professional development and specialist governance training provided regularly to enhance team capabilities and leadership skills.

Implementing these principles and procedures will help ensure that surgical MDT meetings effectively contribute to high standards of patient care, safety, and continuous improvement in surgical services (NHS England, 2019).

Surgical MDT Governance Flowchart



DOMAIN 2: Mortality and Morbidity (M&M) Meetings



The Importance of M&M Meetings in Surgical Governance

Morbidity and Mortality (M&M) meetings are a cornerstone of clinical governance in surgery and are essential for fostering a culture of safety, accountability, and continuous learning within surgical services. As emphasised in the *'Royal College of Surgeons of England's Good Surgical Practice – Morbidity and Mortality Meetings Guidance'*, these meetings provide structured opportunities for surgical teams to reflect critically on adverse outcomes, identify areas for improvement, and promote transparency in clinical decision-making.

M&M meetings serve many critical functions:

- a. **Enhancing Patient Safety:** By openly reviewing complications and adverse outcomes, teams can identify patterns, system failures, or practice deviations that may be contributing to harm, allowing for early intervention and preventative strategies.
- b. **Supporting Professional Development:** M&M meetings offer valuable educational moments for both trainees and consultants, reinforcing best practices and shared clinical wisdom.
- c. **Fulfilling Governance Obligations:** M&M processes align with national and institutional frameworks for incident management and quality assurance, such as the HSE's Incident Management Framework (2020).

Recent reports into patient safety incidents have highlighted the absence of effective multidisciplinary governance, traceability protocols, and informed consent procedures as root causes. These failures may have been identified at an earlier phase with robust M&M systems.

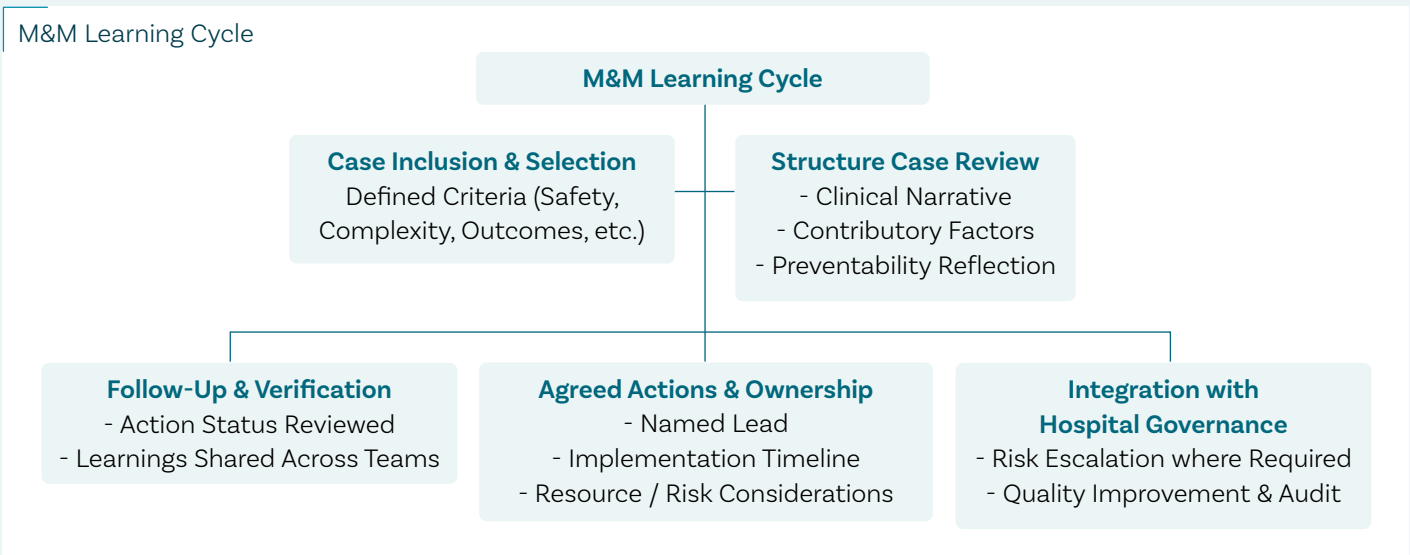
Principles for Effective M&M Meetings

Drawing from RCS England guidance and reinforced by broader governance frameworks, best practices for M&M meetings should include:

- **Regular and Protected Scheduling:** Meetings should be held monthly (or more frequently in high-volume specialties) during working hours with no competing clinical responsibilities. There is a defined process for the establishment and operation of M&M meetings developed by the Healthcare Provider.
- **Multidisciplinary Attendance:** Include not just surgeons but also anaesthesiologists, nurses, radiologists, and other relevant professionals to ensure holistic case analysis.

- **Structured Case Selection and Presentation:** Use pre-agreed criteria for case inclusion. Presentations should follow a standardised format and include reflection on preventability and contributory factors.
- **Supportive, No-Blame Culture:** The environment must be safe for open discussion, avoiding personal blame while maintaining accountability. This reflects HSE principles of fairness and learning from incidents.
- **Transparent Leadership:** There should be a clear and agreed process for the selection and term of the chair of M&M meetings and deputization.
- **Documentation and Follow-Up:** All discussions and action points should be formally recorded, with mechanisms in place to ensure actions are implemented and reviewed at subsequent meetings.
- **Use of Data to Identify Patterns:** Aggregated analysis of cases should be used to detect recurring issues and drive quality improvement initiatives. Any Clinical Data presented should be co-created with the relevant clinical expertise (e.g. A Data Evaluation Panel)
- **Integration with Governance Structures:** Findings and actions from M&M meetings should feed into hospital and national governance systems, including risk registers, quality improvement programmes, and patient safety audits. There should also include a mechanism for escalation or onward reporting as needed.
- **Adequate Resources:** Administrative support and protected time must be allocated by healthcare providers.

In the context of RCSI’s Framework for Clinical Governance in Surgery, M&M meetings should be viewed not just as retrospective reviews but as proactive mechanisms for safeguarding quality, building learning cultures, and enhancing public trust. By embedding M&M reviews into governance structures and aligning them with HSE and HIQA principles, surgical teams can ensure that complications and adverse events are catalysts for positive change.



Appendix 2 is an example of a comprehensive Morbidity & Mortality (M&M) Meeting Template that incorporates best practices from the RCS England guidance, HSE incident management standards, and the objectives of the RCSI Surgical Clinical Governance project. This template is structured to support consistent operation, learning, and governance.

DOMAIN 3: Patient Safety, Risk Management and Clinical Audit



Patient Safety and Risk Management

RCSI recommends that the following strategies, protocols and systems are part of a hospital's Patient Safety and Risk Management programmes. The HSE have published a national risk management framework which will guide the local details of implementation. HIQA National Standards for Safer Better Healthcare requires all healthcare providers to have structured and proactive risk management systems which identify, assess, mitigate and monitor risks to patient safety and service quality.¹⁰

The following components of patient safety and risk management should be established:

Risk Management Strategies: Adherence to national and local hospital policies and guidelines on risk management should be followed in accordance with these requirements and as they change from time to time.

Comprehensive Risk Assessments: Regular risk assessments performed to identify potential hazards associated with surgical procedures, particularly for the introduction and use of implantable medical devices.

Clearly defined and communicated regulatory requirements, particularly concerning medical devices, ensuring adherence to national and international standards.

Emergency Scenario Preparedness: Routine training and simulation exercises for managing surgical emergencies and critical incidents, including system failures and complex surgical scenarios. Specific emergency protocols developed for robotic surgery such as simulating emergency undocking for major haemorrhage and other advanced surgical technologies.¹¹

Documentation and Record-Keeping: Robust documentation practices ensuring complete traceability of all surgical implants and medical devices.

Digital systems to track implants, monitor surgical outcomes, and facilitate prompt intervention if adverse events occur.

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Robust Incident Management Framework: For all HSE funded surgical services, implementation of the HSE Incident Management Framework, which outlines clear processes for immediate reporting, investigation, and analysis of all surgical incidents (*Health Service Executive, 2020*).

For non-HSE funded surgical services, local hospital policies relating to incident management should be followed.

Defined roles, from local accountable officers to senior accountable officers, ensuring timely escalation of significant adverse events.

Structured Reporting and Feedback Loops: Clear pathways for reporting incidents and near misses, supported by feedback mechanisms that relay key learnings directly back to surgical teams.

Transparency and openness fostered through mandatory reporting of adverse incidents, systematic analysis, and public reporting where appropriate.

Alignment with National Standards: Incident reporting systems aligned with national HSE standards to ensure consistency, compliance, and effective integration across the healthcare system.

Essential Patient Safety Protocols

WHO Safe Surgery Checklist: Mandatory use of the WHO Safe Surgery Checklist before all surgical procedures to ensure correct patient identity, procedure, site marking, and equipment availability.

Regular audits of checklist adherence, with accountability mechanisms for addressing non-compliance.

Standardised Safety Protocols: Implementation of hospital-wide protocols covering pre-operative planning, intraoperative management, postoperative monitoring, and discharge planning.

Protocols include clearly defined roles and responsibilities for surgeons, anaesthesiologists, nurses, and allied health professionals.

Clinical Audit

Clinical audits, implant registries and data utilisation play a fundamental role in continuous quality improvement within healthcare, particularly in surgical practice. They involve systematic evaluations of clinical practices against established standards, allowing institutions to measure performance, identify areas for improvement, and monitor the effectiveness of interventions.

The following represents the role of Clinical Audits, Implant Registries and Data Utilisation in continuous quality improvement:

Monitoring and Assurance: Clinical Audits and Implant Registries provide a systematic method for reviewing patient outcomes, processes, and service quality, ensuring adherence to standards and protocols.

Identifying Best Practices and Shortcomings: Audits and Registries highlight exemplary practices worth emulating and areas requiring intervention, thus facilitating evidence-based practice changes and promoting a culture of accountability and continuous improvement.

Improving Patient Safety: By analysing audit and registry data, hospitals can proactively address potential safety risks, implement preventive measures, and foster safer clinical environments.

Transparency and Accountability: Regular audits, registry reports and data sharing enhance transparency, builds trust among staff, patients, and families, and hold teams accountable for quality care and patient outcomes.

METHODOLOGY FOR REGULAR AUDIT ACTIVITIES:

- **Planning and Preparation:** Define clear audit objectives based on clinical standards and evidence-based guidelines.
- **Data Collection:** Systematically collect relevant clinical and administrative data.
- **Analysis and Interpretation:** Analyse data to assess performance against benchmarks.
- **Action Planning:** Formulate action plans based on insights gained.

- **Implementation:** Execute identified changes or improvements.
- **Re-audit:** Regularly repeat the audit to confirm effectiveness and continuous improvement.
- **Audit Tools and Checklists:** Utilisation of standardised checklists and guidelines specific to clinical procedures or pathways, such as surgical safety checklists, to streamline and maintain consistency in audit processes.

Data Integration Approaches are necessary to support effective clinical governance and assurance of patient safety. *The following strategies are important:*

Centralised Data Management Systems:

- Establishing comprehensive, hospital-wide or system-wide Electronic Health Record (EHR) systems capable of integrating clinical data from various sources including surgical outcomes, adverse events, and procedural compliance data.

Data Sharing and Collaboration:

- Development of multidisciplinary team structures and committees responsible for regular review of integrated clinical data to encourage cross-disciplinary learning and collaborative quality improvement.
- Co-creation of data sets with the appropriate clinical and technical expertise should be in place. Consider using a committee such as “Data Evaluation Panel” which would be responsible for balancing outcome clinical data with other factors such as complexities, co-morbidities and case mix.
- Engaging with specialist agencies such as NOCA (National Office for Clinical Audit) with respect to data sharing and data analysis can strengthen data dissemination among those responsible for change and resourcing prioritisation.

Real-time Monitoring Systems:

- Implementation of real-time dashboards and surveillance systems to continuously monitor KPIs enabling prompt responses to emerging issues or deviations from expected clinical standards.

The following actions are recommended based on Audit or Registry Reports:

Multidisciplinary Team Engagement:

- Engage clinical teams to review audit and registry findings, fostering collective accountability for developing solutions to identified issues. A multidisciplinary approach ensures that diverse expertise informs improvement efforts.

Targeted Quality Improvement Initiatives:

- Initiate specific quality improvement projects addressing identified deficits, utilising methodologies such as Plan-Do-Study-Act (PDSA) cycles or other continuous improvement frameworks.

Enhanced Training and Education:

- Provide ongoing, targeted training for staff to address gaps highlighted by audit or registry data, ensuring clinical competencies align with best practices and updated guidelines, especially during the introduction of new technologies such as robotic surgery and implantable devices.

Policy and Protocol Revision:

- Regularly revise clinical guidelines, standard operating procedures, and institutional policies based on insights from audits to ensure they reflect current best practices and regulatory requirements.

Open Disclosure and Patient Communication:

- Implement robust open disclosure practices where audit findings involving adverse outcomes or deviations from standards are transparently communicated to patients and families, supporting trust and informed decision-making.

By consistently employing structured clinical audits, implant registries and integrating robust data systems, and fostering responsive and transparent actions based on findings, healthcare organisations can effectively drive continuous improvement in surgical quality, enhance patient safety, and achieve higher standards of clinical governance.

Patient Safety - Training and Education Programmes

Ongoing training for all surgical staff on clinical governance procedures, ethical considerations, informed consent, and regulatory requirements for new surgical technologies and devices.

Structured oversight during the learning phases of new technologies, reducing patient risk during surgeon learning curves.

TRAINING AND COMPETENCY STANDARDS

Robotic surgery governance guidance from RCSI underscores the importance of structured, standardised training and credentialing for surgeons, particularly during their learning phases. This applies to all novel or innovative practices. This approach mitigates patient risks and assures ethical adherence to patient safety standards. Continuous Professional Development (CPD) and competency assessments are recommended to ensure high-quality outcomes.

These elements collectively foster a healthcare environment prioritising patient safety, clinical excellence, and ethical practice, essential for high-quality, patient-centered surgical governance.

Access to dedicated training programmes and structured induction for clinical governance and leadership skills should be supported for individuals with responsibility and accountability for surgical clinical governance.

All Surgeons and Surgical Trainees should be encouraged and supported to participate in CPD relating to Surgical Clinical Governance and related matters.

Hospital Governing Bodies and Management should provide protected time to allow staff engagement with governance and quality improvement activities.

To build a culture of continuous learning with respect to patient safety, regular forums, workshops, and structured learning sessions should be held to disseminate lessons learned from incidents and promote best practices. Encouragement of open discussion and transparency regarding surgical errors and adverse events to facilitate systemic learning and improvement.

Education, training, and workforce development activities necessary for supporting surgical governance should encompass CPD, specialist governance training, and protected time allocations. Based on the comprehensive documentation and recommendations reviewed, the following detailed framework emerges:

CPD is critical for maintaining and advancing the competencies of surgical teams, ensuring alignment with evolving clinical governance practices and standards. Some essential CPD activities may include:

Active participation in clinical audits for continuous performance review.

- Encouragement of reflective practice to identify and rectify gaps in clinical care.
- Systematic training in new surgical techniques and technologies, such as robotic surgery, implantable devices and other minimally invasive methods, ensuring safe implementation and use.
- Ongoing education sessions related to the latest clinical guidelines, patient safety protocols, and governance frameworks.
- Training staff in recognising, reporting, and reviewing incidents to learn and prevent recurrence. Integration of incident management training into regular professional development activities, emphasising transparency and accountability.

SPECIALIST GOVERNANCE TRAINING

Specialist governance training programs should be provided to embed a robust culture of quality, safety, and leadership across surgical practices. Recommended approaches include:

Leadership Development:

- Courses specifically tailored for Regional Clinical Directors, Regional Clinical Leads, Clinical Directors and Perioperative Clinical Directors as well as other clinical governance leaders, emphasising leadership skills, team management, conflict resolution, and effective communication.
- Mentorship programs pairing experienced leaders with developing surgical governance leaders to foster professional growth.

Multidisciplinary Team (MDT) Training:

- Formal training sessions that promote effective multidisciplinary collaboration, improving team dynamics and communication to ensure comprehensive patient care and informed decision making.
- Simulation-based training to enhance teamwork and preparedness for handling complex and emergency situations.

Regulatory and Ethical Compliance Training:

- Detailed training programs that ensure all surgical team members understand medical device regulations, particularly the correct use and governance of implantable devices, compliance with CE marking, and adherence to ethical standards.

Quality Improvement Methodologies:

- Training in methodologies such as Lean Management, Six Sigma, or Plan-Do-Study-Act (PDSA) cycles to foster an environment of continual improvement in clinical practice.

To ensure effectiveness and dedicated focus on governance-related activities, protected time is essential:

• **Allocation for Training and CPD:**

Scheduled, protected periods during clinical hours specifically dedicated to attending training, educational courses, and engaging in reflective practice.

• **Dedicated Clinical Governance Time:**

Specific, protected time for surgeons and clinical leaders to engage in governance-related tasks, including team meetings, incident reviews, audits, and planning of quality improvement initiatives. Clear policies mandating time allocations for governance tasks to avoid encroachment by clinical duties.

• **Support for Governance Roles:**

Provision of dedicated administrative and clinical governance support staff, facilitating effective use of allocated protected time for surgeons.

Structured roles and clear responsibilities for governance activities, ensuring efficient use of time and preventing role confusion or overload.

By embedding these structured activities and providing adequate support through training, CPD, and protected time, healthcare organisations can effectively enhance their surgical governance, ensuring safety, quality, and continuous improvement in patient care.

PATIENT SAFETY: PATIENT AND FAMILY ENGAGEMENT:

Proactive engagement and transparent communication with patients and families, especially when treatments deviate from standard practice or following adverse events are essential for patient centred care and effective communication. Health providers should recognise the importance of facilitating surgeons to participation in important family meetings.

There should be effective open disclosure policies consistently applied to maintain trust and patient-centered care.

These detailed protocols, strategies, and mechanisms provide a structured and evidence-based foundation for enhancing surgical safety, ensuring consistent adherence to high standards of care, and fostering a culture of accountability, transparency, and continuous learning.

Patient involvement and ethical oversight, including informed consent procedures, patient communication standards, feedback mechanisms, and ethical oversight structures, play a crucial role in effective clinical governance and quality healthcare delivery. Outlined below is a comprehensive discussion on these aspects based on the documents reviewed, with specific references to surgical clinical governance practices.

INFORMED CONSENT PROCEDURES

Informed consent is fundamental to ethical patient care, ensuring patients are fully informed of treatment risks, benefits, and alternatives. Key findings from recent HIQA recommendations stress the need to improve processes around obtaining informed consent, especially when treatments involve implantable medical devices or novel, experimental procedures. It emphasises clear, thorough, and documented communication with patients and families to ensure truly informed consent, thereby protecting patient autonomy and enhancing safety (HIQA, 2024).

For new and emerging technologies such as robotic assisted surgery, consent processes must explicitly communicate the distinct risks and benefits associated with robotic-assisted procedures. This ensures patient understanding, particularly during a surgeon's learning curve, which is critical for patient safety during initial phases of robotic procedures.

PATIENT COMMUNICATION STANDARDS

Effective patient communication is integral to patient-centered care. The HSE Incident Management Framework (IMF) emphasises open disclosure, which involves timely, empathetic, and transparent communication following patient safety incidents. This includes informing patients about what happened, actions taken, ongoing care and treatment, and preventive measures being implemented (Health Service Executive, 2020).

This principle is echoed by RCSI's guidance on robotic surgery governance, where proactive, transparent communication with patients, particularly in novel or innovative surgeries, is essential. Hospitals are encouraged to have clearly defined communication standards to keep patients informed and engaged throughout their treatment journey.

Feedback Mechanisms

Establishing mechanisms for capturing patient and family feedback is vital for continuous improvement. According to the clinical governance frameworks discussed in the Royal Australasian College of Surgeons (RACS) report, healthcare organisations with good governance systems actively engage patients in evaluating care through structured feedback mechanisms. This practice enables real-time adjustments and improvements, fostering a culture focused on learning and quality enhancement (Royal Australasian College of Surgeons, 2017).

The Incident Management Framework by the HSE highlights the importance of structured feedback systems after incidents, advocating a person-centered response that incorporates learning from patient and staff experiences into ongoing safety improvements.

Ethical Oversight Structures

Ethical oversight involves systems and structures ensuring clinical decisions and practices align with professional standards and ethical principles. The RACS report identifies key characteristics of organisations excelling in clinical governance, such as clear accountability structures, open disclosure policies, and ethical review mechanisms, especially critical during the introduction of new medical devices or surgical techniques.

HIQA's recent independent review of governance at Children's Health Ireland (CHI) further underscores the importance of robust ethical oversight structures for the introduction and use of implantable medical devices, including rigorous multidisciplinary and ethical reviews prior to introducing new or experimental interventions. Specifically, HIQA recommended enhancing clinical governance structures to clearly define responsibilities and accountabilities, and to simplify reporting and decision-making structures to maintain patient safety and quality standards.

DOMAIN 4: Practice Innovation, Research and New Technologies



Innovation is integral to surgical practice, but it must be introduced through a rigorous, transparent and patient-centred governance process. Surgeons recognise that new technologies, robotics, data-driven tools, Apps and AI-driven systems will be essential to the next decade of surgical practice, yet also report concerns about skill shortages, inconsistent oversight and variable preparedness across hospitals.^{12 13}

This surgical governance domain ensures that Irish surgical departments adopt new techniques, technologies and research practices safely, ethically and consistently, aligned with national and international standards. It supports:

- Responsible introduction of innovation.
- Protection of patients from unmanaged or poorly evaluated risk.
- Improved transparency when new approaches are used.
- Appropriate training and credentialing.
- Alignment with research governance, data protection, ethics and regulatory standards.
- Long-term readiness for emerging technologies.

Timely review of proposals for new treatments, procedures or use of new technologies is needed to ensure patients have access to advances and innovations in care.

Principles for Governance of Innovation and New Technologies

- **Safety First, Evidence-Led Adoption**
All new surgical techniques or technologies must be introduced based on peer-reviewed evidence, recognised standards and with a documented risk-benefit evaluation.
- **Clear Accountability and Oversight Structures**
Hospitals must have a defined committee with responsibility for authorising new procedures technology adoption, ensuring ethical and regulatory compliance, verifying surgeon competency and maintaining ongoing evaluation.
- **Research Governance Compliance**
All research must follow national ethical requirements, GDPR, proper consent and trial governance processes.

- **Transparency and Patient Communication**

Patients must be informed when a procedure involves a novel technique, new device or research involvement.

- **Multidisciplinary Review of New Techniques**

Novel techniques and emerging technologies should be reviewed through MDT structures as part of risk mitigation.

- **Continuous Monitoring, Audit and KPI Tracking**

New technologies must undergo structured outcome monitoring, including KPIs, complication reviews and governance oversight.

Introducing New Surgical Practices or Technologies – Required Process

Healthcare providers should establish a clear process and timelines which governs the safe introduction of new technologies and practices in the delivery of surgical services. The following outlines a proposed approach which supports the safe introduction of the necessary innovations in surgical practice. New technologies, Apps, devices, tools and procedures represent important opportunities for patient outcomes.

STEP 1: Proposal Submission

A structured application outlining evidence, benefits, risk, regulatory implications, training needs and monitoring proposal. The application for the introduction of a new technology, innovation or practice should have a general consensus of the surgical peer group.

STEP 2: Committee Review

Evaluation of safety, evidence base, resource readiness, governance obligations and alignment with hospital capability.

STEP 3: Training and Competency Assurance

Surgeons must demonstrate training and competency prior to introduction.

STEP 4: Controlled Introduction

Defined case selection, proctoring and staged rollout.

STEP 5: Early-Phase Audit and Monitoring

Monitoring of key indicators with review through MDT and M&M processes.

STEP 6: Ongoing Review or Full Approval

Decision on continuation, modification or cessation based on outcome review.

Surgical Practice Research and Clinical Trials must comply with all research ethics processes, consent, GDPR, data governance, trial regulation and adverse event reporting.

AI and digital tools, including Apps require transparency, validation, data protection, algorithmic oversight and defined risk controls before their introduction. Hospital executives must ensure protected governance time, administrative support, training resources and alignment with organisational policies.

Surgeons must maintain competency, declare conflicts of interest, engage with MDT/M&M, document appropriately and uphold regulatory standards. Structured governance ensures that Irish surgical innovation remains safe, ethical and sustainable while supporting clinicians and patients.

Implementation Roadmap for Surgical Clinical Governance Framework



This Implementation Roadmap is designed to support hospitals, surgical departments and clinical leadership teams in adopting this Framework in a structured, progressive and sustainable manner. It recognises that surgical services across Ireland are operating within differing organisational contexts and levels of governance maturity and therefore allows for phased development over time.

The objective of this roadmap is to ensure that the principles and standards outlined in this Framework are translated into **practical, operational and measurable governance processes** that enhance patient safety, strengthen accountability and support continuous learning within surgical practice.

Implementation should be undertaken as a partnership between:

- Surgical governance leadership within services.
- Hospital management and executive governance structures.
- Clinical directors and directorates.
- Multidisciplinary clinical teams and trainees.

and must be appropriately resourced, supported and monitored at organisational level.

A Department of Surgery: Minimum Construct

Many hospitals will have varied structures on how surgical and perioperative services are organised, managed, staffed and governed. These structures and reporting pathways will likely be in accordance with national policies for

organisations such as the HSE. Understanding what is generally understood as “A Department of Surgery” would have the following elements, but these are not prescriptive and more of a guide to assist hospital leadership.

1. Leadership & Accountability

There is a Named Clinical Director for Surgery and Specialty Clinical Leads. There is also a clearly documented reporting line to hospital management structures.

2. Core Governance & Meetings

Regular surgical departmental governance meetings are held. This is in addition to the M&M and MDT meetings as per previous sections. There would be regular (e.g. Quarterly) review of agreed KPI and metrics with hospital Corporate Leadership and/or Clinical Director. All meetings to be documented with actions and owners. There should be an allocated level of adequate administrative support dependent on the size of the department.

3. Patient Safety & Quality Metrics

The following represents typical surgical quality and safety indicators, this not exhaustive and should be co-created by surgical and hospital leadership.

- Deaths and Unexpected Deaths
- Surgical Site Infections
- Unplanned Return to Theatre
- Unplanned ICU Admission
- Serious Incidents / Never Events

These would be linked to a surgical risk register with documented risk escalation pathway.

4. Access & Performance

Co-creation between hospital management/leadership and surgical leadership of the following key measurable elements such as, but not limited to:

- Theatre Utilisation
- Case Cancellations
- Outpatient New:Return Ratios
- Waiting List Size and Long Waiters

5. Workforce Sustainability

The departmental meeting should, from time to time, consider Consultant and NCHD staffing levels, on-call and rota risks, education and training related supports.

Phase 1: Establishing Governance Foundations

The first phase focuses on identifying current practice, clarifying leadership roles and establishing the minimum structures required to support safe and effective surgical governance.

Key Actions

- Appointment or confirmation of a **Surgical Governance Lead** (or equivalent role) with defined responsibilities and time allocation.
- Mapping of existing MDT and M&M meeting structures, including:
 - ~ Frequency, attendance and participation
 - ~ Availability of administrative and IT support
 - ~ Documentation and follow-up mechanisms
- Review of existing reporting pathways into:
 - ~ Hospital clinical governance committees
 - ~ Risk and incident management systems
 - ~ Quality and safety functions
- Identification of areas where:
 - ~ Governance activity is already well-established
 - ~ Practice is inconsistent or informal
 - ~ Structures require development or strengthening

This phase should result in a clear baseline understanding of current governance arrangements within the surgical service and the level of alignment with the standards contained in this Framework.

Phase 2: Standardising Core Governance Processes

The second phase focuses on ensuring that core elements of surgical governance are delivered in a consistent, transparent and reliable manner across all services and specialties.

Key Actions

- Standardisation of MDT and M&M meeting processes, including:
 - ~ Defined case-selection criteria
 - ~ Structured presentation format
 - ~ Documented decision-making and agreed actions
- Introduction or strengthening of:
 - ~ Administrative support for meeting preparation, minutes and follow-up
 - ~ Protected time for meaningful participation by consultants and trainees
 - ~ IT and digital supports for case records and review
- Alignment of MDT and M&M outputs with:
 - ~ Service audit programmes
 - ~ Risk and incident learning systems
 - ~ Local quality improvement initiatives
- Clarification of leadership responsibilities for:
 - ~ Chairing and facilitation of meetings
 - ~ Escalation of systemic risks or trends
 - ~ Oversight of action completion and learning dissemination

The purpose of this phase is to ensure that surgical governance processes are not only present, but are **structured, reliable and functioning as part of the wider organisational governance system.**

Phase 3: Embedding Learning, Accountability and Continuous Improvement

The third phase supports the transition from governance activity as a process, to governance as a **culture of learning, reflection and system improvement**.

Key Actions

- Development of a **surgical governance work programme**, incorporating:
 - ~ Regular thematic audit and review
 - ~ Monitoring of recurring risks or trends
 - ~ Patient involvement where appropriate
- Routine review of:
 - ~ Action logs from MDT and M&M meetings
 - ~ Evidence of implementation and impact
 - ~ Barriers to learning or follow-through.
- Integration of governance findings into:
 - ~ Workforce planning and training needs analysis
 - ~ Service redesign and pathway improvement
 - ~ Organisational quality and safety reporting
- Periodic self-assessment of governance maturity against:
 - ~ Locally defined objectives
 - ~ Organisational governance expectations
 - ~ National professional standards.

At this stage, governance activity should be embedded as a normal component of surgical practice, contributing to safer patient care, higher reliability and a **proactive approach to quality improvement**.

Implementation of this Framework should be:

- **Clinically led and organisationally supported** with visible sponsorship from hospital leadership.
- **Resourced and sustainable** including administrative support, IT infrastructure and protected time.
- **Inclusive and multidisciplinary** recognising the contribution of the full surgical team.
- **Transparent and evidence-informed** with clear documentation and escalation pathways.
- **Developmental rather than punitive** supporting learning, professionalism and reflective practice.

Surgical Governance Maturity Model



This Governance Maturity Model is intended to support surgical services in understanding their current level of governance development and in planning progressive improvement over time. It provides a structured framework through which services can assess the extent to which their governance arrangements are embedded, reliable and integrated within wider organisational systems.

The model recognises that services operate in differing contexts, and that development is both iterative and collaborative. It should therefore be used as a tool for reflection, service improvement and prioritisation, rather than as a compliance or performance mechanism.

Progression through the maturity levels may occur at different rates across specialties or sites. The objective is not uniformity of pace, but a shared trajectory towards safe, transparent and learning-oriented surgical governance.

Level 1: Governance Foundations

At this level, governance activity is present but is dependent on individual professional commitment rather than structured systems.

Typical Characteristics

- MDT and/or M&M meetings occur, but:
 - ~ Frequency may be inconsistent
 - ~ Attendance varies across disciplines and grades
- Documentation is limited or not routinely retained
- Case selection is based on local practice rather than agreed criteria.
- Actions arising from meetings are not systematically tracked or reviewed.
- Links with hospital quality, risk or audit structures are partial or ad-hoc.
- Leadership roles and responsibilities for governance are present but not clearly defined.
- Health provider allocates none or minimal resources and there is a lack of a defined structure.

Development Priorities

- Clarifying leadership responsibility and reporting structures
- Allocating resources and systems to support surgical clinical governance
- Establishing minimum standards for meeting processes
- Introducing consistent documentation and action recording.

Level 2: Emerging Structured Governance

At this level, governance processes are established and more consistent, with allocated resources and with clearer expectations and improved reliability of practice.

Typical Characteristics

- MDT and M&M meetings:
 - ~ Occur regularly
 - ~ Follow a broadly consistent format
 - ~ Include representation from relevant specialties where possible
- Minutes, agreed actions and case summaries are recorded for most meetings.
- Administrative support is available in part, or for some specialties.
- Some escalation of systemic issues occurs, though mechanisms may be evolving.
- Protected time is recognised as important, but may not be fully formalised.

Development Priorities

- Strengthening administrative support and digital record-keeping.
- Embedding follow-up review of actions.
- Aligning outputs with audit and incident learning systems.

Level 3: Established and Integrated Governance

At this level, governance activity is embedded as a routine and accountable component of surgical service delivery.

Typical Characteristics

- MDT and M&M meetings are:
 - ~ Structured, recorded by way of minutes and action-focused
 - ~ Supported by administrative and IT resources
 - ~ Attended by appropriate decision-makers
- Case selection criteria are defined and applied consistently.
- Action logs are reviewed at subsequent meetings, with clear ownership and timeframes
- Findings inform:
 - ~ Service audit and quality improvement
 - ~ Risk escalation and organisational learning
- Leadership roles for chairing, facilitation and escalation are defined and understood.
- Governance participation is supported through protected time.

Development Priorities

- Strengthening thematic learning across specialties and sites.
- Increasing visibility of outcomes at hospital governance level.

Level 4: Exemplar Learning and Improvement Culture

At this level, governance systems are proactive, reflective and contribute to continuous improvement across the wider organisation.

Typical Characteristics

- MDT and M&M activity is:
 - ~ Consistently evidence-informed
 - ~ Focused on learning and patient outcomes
 - ~ Supported by reliable data and follow-up processes
- Themes and trends are:
 - ~ Analysed over time
 - ~ Shared across departments or networks
 - ~ Inform service redesign and training needs
- Psychological safety, openness and respectful challenge are actively supported.
- Governance outputs:
 - ~ Feed into strategic planning and workforce development
 - ~ Contribute to national learning where appropriate
- The service demonstrates a culture where professionalism, accountability and improvement are normal features of practice.

Ongoing Priorities

- Sustaining engagement across disciplines and career stages.
- Maintaining balance between assurance, learning and innovation.

Use of the Maturity Model

Services may use this model to:

- Undertake periodic self-assessment.
- Identify areas for targeted improvement.
- Inform local governance work programmes.
- Support discussion with hospital management and executive teams.

The model is not intended to replace organisational performance processes, but to provide a **constructive, developmental lens** through which surgical governance can strengthen over time.

Governance Maturity Matrix Model – To Aid Self-Assessment

Governance Areas	Level 1 Developing Foundations	Level 2 Emerging Structured Governance	Level 3 Established & Integrated Governance	Level 4 Exemplar Learning & Improvement Culture
Governance Structures & Leadership	Governance activity present but informal; roles not clearly defined; reliance on individual commitment.	Governance responsibilities identified; leadership roles clearer but evolving. There is a clearly defined and documented Surgical Department	Defined leadership roles for chairing, escalation and oversight; reporting lines established.	Governance fully embedded within hospital structures; leadership distributed and visible
MDT & M&M Meeting Function	Meetings occur variably; limited consistency of format or frequency.	Meetings held regularly with broadly consistent approach across specialties.	Structured, minuted, action-focused meetings with clear participation and decision-making.	Meetings function as proactive learning forums that inform practice and system improvement.
Case Selection & Review Processes	Case selection informal and based on local custom; limited criteria.	Increasing use of agreed case-selection criteria in some specialties.	Case selection criteria consistently applied and reviewed.	Themes and trends reviewed longitudinally across services and specialties.
Documentation, Actions & Follow-Up	Minutes and actions inconsistently recorded; limited review of outcomes.	Documentation improving; some follow-up processes in place.	Action logs reviewed at subsequent meetings with clear ownership and timescales.	Outcomes monitored for impact; learning disseminated across teams and sites.
Administrative & Digital Support	Minimal or absent administrative or IT support.	Partial administrative support available; digital records developing.	Dedicated administrative and IT support for preparation, recording and follow-up.	Data systems enable longitudinal review, learning and quality improvement.
Integration with Hospital Governance & Risk Systems	Limited or ad-hoc escalation into hospital structures.	Some alignment with audit and incident learning processes.	Governance outputs routinely linked to quality, audit and risk functions.	Findings inform service redesign, workforce planning and organisational strategy.
Protected Time & Participation	Participation dependent on goodwill and availability.	Recognition of need for protected time, not yet consistent.	Protected time supported for meaningful participation.	Engagement sustained across disciplines and career stages.
Culture, Learning & Professionalism	Variable reflection and learning; culture dependent on local context.	Increasing openness and shared learning in meetings.	Learning culture embedded with shared accountability and respectful challenge.	Strong psychological safety; proactive improvement culture evident across the service.



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Appendices

1. Morbidity and Mortality (M&M) Meeting Template *(For Use in Surgical Services)*

1. Meeting Information Available

2. Attendance Log *(Attach a signed attendance sheet or use electronic form submission)*

3. Agenda Structure

- Welcome & Purpose Reminder
- Review of Previous Actions
- Case Presentations & Discussions
- Thematic Trends / Data Review
- Governance Issues & Risk Updates
- Action Planning
- Close & Next Meeting Date

4. Case Discussion Template *(Repeat for each case)*

4.1 Case Overview

4.2 Clinical Summary

- ~ Brief clinical history and indication for surgery
- ~ Key intraoperative and postoperative details
- ~ Timeline of events and escalation

4.3 Contributing Factors *(tick if applicable)*

- Technical error
- Communication breakdown
- Delay in diagnosis/intervention
- Documentation issue
- System/process failure
- Equipment/device issue
- Patient-specific complexity
- Other (specify): _____

4.4 Preventability Rating

4.5 Lessons Learned

- What could have been done differently?
- System/process improvement points

5. Actions and Ownership

6. Meeting Close

- Confirmation of actions
- Date/time of next meeting:
- Feedback on the meeting process (optional short form or verbal)

2. Surgical MDT & M&M Minimum Dataset Templates

Multidisciplinary Team (MDT) Meeting – Example Case Presentation Template

This template is intended to support consistent documentation of MDT activity in Irish hospital surgical services. Fields may be adapted to reflect local service structures while retaining core dataset items.

Hospital / Site	Date of Meeting	Start Time	Finish Time
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Specialty / MDT Type			
<input type="text"/>			
MDT Chair	Attendees (Consultants / NCHDs / Nursing / AHPs / Others) <i>(Attach a signed attendance sheet or use electronic form submission)</i>		
<input type="text"/>	<input type="text"/>		
Administrative Support (Name/Role)			
<input type="text"/>	<input type="text"/>		
Apologies	Quorum / Decision-Making Attendance		
<input type="text"/>	<input type="text"/>		
Presenting Consultant / Team		Case Identifier / MRN <i>(local convention)</i>	
<input type="text"/>		<input type="text"/>	
Reason for MDT Review	Patient Age	Patient Sex	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Clinical Summary	Diagnostics/Imaging Reviewed		
<input type="text"/>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Options Considered			
<input type="text"/>			
Agreed Management Decision / Recommendation		Named Responsible Consultant / Lead	
<input type="text"/>		<input type="text"/>	
		Expected Timeframe for Actions	
		<input type="text"/>	
Actions Required		Communication to Patient/Family <i>(if appropriate)</i>	
<input type="text"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO	
		Follow-Up Plan/Review at Future MDT	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Issues Requiring Escalation		Linkage to Audit/QI/ Risk Processes	
<input type="text"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO	
Minutes Completed By		Date Minutes Filed / Circulated	
<input type="text"/>		<input type="text"/>	

Morbidity & Mortality (M&M) Meeting – Example Case Presentation Template

This template supports structured, learning-focused review of clinical cases. It should be used in line with local governance policy and professional standards.

Hospital / Site	Date of Meeting	Start Time	Finish Time
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Specialty / Service			
<input type="text"/>			
M&M Chair	Attendees (Consultants / NCHDs / Nursing / AHPs / Others) <i>(Attach a signed attendance sheet or use electronic form submission)</i>		
<input type="text"/>	<input type="text"/>		
Administrative Support (Name/Role)	<input type="text"/>		
<input type="text"/>	<input type="text"/>		
Presenting Consultant / Team	Case Identifier / MRN <i>(local convention)</i>		
<input type="text"/>	<input type="text"/>		
Clinical Scenario / Timeline Summary	Indication for Inclusion (criteria / learning value)		
<input type="text"/>	<input type="text"/>		
Outcome / Complication Description			
<input type="text"/>			
Clinical / System Factors Contributing	Were Care Standards Followed?		
<input type="text"/>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Preventability (Professional Judgement)	Key Learning Points		
<input type="text"/>	<input type="text"/>		
Agreed Actions	Named Action Owner		
<input type="text"/>	<input type="text"/>		
Resources / Supports Required	Target Completion Date		
<input type="text"/>	<input type="text"/>		
Plan for Learning Dissemination	Review of Previous Actions <i>(if applicable)</i>		
<input type="text"/>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Date Action Status Reviewed	Escalation Required (Yes / No)		
<input type="text"/>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Minutes Completed By	Linkage to Audit/QI/ Risk Processes		
<input type="text"/>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Minutes Completed By	Date Minutes Filed / Circulated		
<input type="text"/>	<input type="text"/>		



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