West Dunbartonshire Council | NHS Greater Glasgow and Clyde | West Dunbartonshire Health & Social Care Partnership

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
CLINICAL AND CARE GOVERNANCE ARRANGEMENTS

Context

At the end of 2014 the Scottish Government published its first unified framework for Clinical and Care Governance[1]. This Framework was based on the Governance for Healthcare Quality in Scotland – An Agreement (2013) and also a comparable document which was produced by Social Work Scotland. The Framework states that all aspects of the work of Integration Authorities, Health Boards and local authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care. The Framework emphasises five key principles – that:

- Clearly defined governance functions and roles are performed effectively.
- Values of openness and accountability are promoted and demonstrated through actions.
- Informed and transparent decisions are taken to ensure continuous quality improvement.
- Staff are supported and developed.
- All actions are focused on the provision of high quality, safe, effective and person-centred services.

The West Dunbartonshire Integration Scheme - in keeping with the national framework – confirms the following with respect to the HSCP:

- Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured, supporting staff in continuously improving the quality and safety of care and ensuring that wherever possible poor performance is identified and addressed.
- Effective clinical and care governance arrangements need to be in place to support the delivery of safe, effective and person-centred health and social care services within integrated services.
- Clinical and care governance for integrated health and social care services requires co-ordination across a range of services, (including procured services) so as to place people and communities at the centre of all activity relating to the governance of clinical and care services.

It is important to acknowledge that the HSCP is not working from a "blank page" – a host of protection/improvement/ scrutiny activity is on-going across the organisation, often described in differing terms. A recent (September 2015) guidance note jointly prepared by the Scottish Government's Chief Social Work Adviser and Divisional Clinical Lead - Healthcare Quality and Strategy poses a number of questions for HSCPs to reflect upon when devising their individual systems for clinical and care governance:

- What has worked well within NHS clinical governance; and in what ways might this influence how the local integration authority approaches clinical and care governance?
- What has not worked well and what testing/learning could be undertaken to explore how that integration authority will receive information on:
  - Quality of care.
  - Actions to sustain or improve quality of care.
  - Monitoring of the impact of these actions.
  - Review of impact of these actions against strategic priorities and outcomes.

[1] http://www.gov.scot/Resource/0046/00465077.pdf

Clinical Governance – Some Food for Thought

For most of its first four decades, the NHS worked with an implicit notion of quality, building on the philosophy that the provision of well trained staff, good facilities, and equipment was synonymous with high standards – essentially, clinicians were inherently good people who could and should be trusted to do good work[2]. The quality initiatives that followed – notably clinical audit - adopted a more systematic approach. However, they were often criticised as professionally dominated and somewhat insular activities whose benefits were not readily apparent to either patients or the organisations in which they were undertaken[3].

Prior to 1999, the principal statutory responsibilities of NHS Boards were to ensure proper financial management of the organisation and an acceptable level of patient safety. NHS Boards had no statutory duty to ensure a particular level of quality, as maintaining and improving the quality of care was understood to be the responsibility of the relevant clinical professions. In 1999, NHS Boards assumed a legal responsibility for quality of care equal in measure to their other statutory duties. Clinical governance was and is the mechanism by which that responsibility would be discharged, placing a statutory responsibility for ensuring quality health care on the chief executives of those organisations.

The most widely referenced definition of clinical governance describes it as "*a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish*.[2] This definition is intended to embody three key attributes: *recognisably high standards of care*; *transparent responsibility and accountability for those standards*; and *a constant dynamic of improvement*.

There are traditionally seven key components (pillars) of clinical governance[4]:

1. Information (encompassing performance review and information governance).
2. Risk Management (including clinical incident reviews – and equivalent to critical incident and significant case reviews).
3. Patient and Carer experience and involvement (including complaints management).
4. Clinical Audit (equivalent to other comparable critical self-evaluation "cycles" of Plan-Do-Study-Act/small tests of change/Public Sector Improvement Framework/case file audits).
5. Clinical Effectiveness and Research (including the application of guidance).
6. Staffing and staff management.
7. Education, training and continuing personal and professional development (including accreditation and revalidation).

Strategic capacity - i.e. high level planning and capabilities - can also be considered as important to clinical governance, although they are not counted amongst the seven pillars. It is important to realise that the separation between the pillars is something which is done for convenience sake – in practice they are not necessarily or indeed frequently discrete areas (e.g. evidence or results of clinically effective practice or audit, may rely on information mechanisms and/or education and training sessions for dissemination).

The concept has its antecedents in *corporate governance*[5] (which was itself formulated to redress failing standards in the business world), with both corporate and clinical governance being primarily concerned with those *structures, systems and processes that assure the*

[2] Halligan A, Donaldson LJ. Implementing clinical governance: turning vision into reality. BMJ 2001; 322;1413-1417.
[3] Thomson RG, Donaldson LJ. Medical audit and the wider quality debate. J Pub Health Med. 1990; 12: 149–151.
[4] Nicholls S, Cullen R, O'Neill S, Halligan A. Clinical governance: its origins and its foundations. British Journal of Clinical Governance 2000; 5 (3):172 – 178.
[5] Financial Aspects of Corporate Governance (The Cadbury Report), 1992: http://www.ecgi.org/codes/documents/cadbury.pdf

quality, accountability and proper management of an organisation's operation and delivery of service. However clinical governance applies only to health and social care organisations, and only those aspects of such organisations that relate to the delivery of care to patients and their carers; it is not concerned with the other business processes of the organisation except insofar as they affect the delivery of care. In their seminal article, Scally & Donaldson[6] noted that the resonance of the two terms – i.e. corporate governance and clinical governance - is important, for if clinical governance is to be successful it must be underpinned by the same strengths as corporate governance: it must be *rigorous in its application*; *organisation-wide in its emphasis*; *accountable in its delivery*; *developmental in its thrust*; and *positive in its connotations*.

Clinical governance was developed as a means to integrate previously rather disparate and fragmented approaches to quality improvement - but there was another driver for change. A series of high profile failures in standards of NHS care during the mid-1990s caused deep public and professional concern and threatened to undermine confidence in the NHS[2]. Given more recent events it is important to appreciate the on-going relevant of why clinical governance was established in the first place; and also understand that "just" having a clinical governance structure or the term being common currency amongst either managers or clinicians within a health board is clearly not in itself sufficient. Given that clinical governance is fundamentally intended to be a system of quality assurance, the following points made within the Vale of Leven Hospital Inquiry Report (2014)[7] are worthy of reflection:

- *It was surprising how many managers at different levels within an organisation like NHSGGC failed in one of the more fundamental aspects of management, namely to ask questions.*
- *This can only be described as a management culture that relied upon being told about problems rather than actively seeking assurance about what was in fact happening.*
- *The clear lesson to be learned is that an important aspect of management is to be proactive and obtain assurance that systems and personnel are functioning effectively.*

Challenges

It is worth explicitly recognising that there are tensions within the notion of clinical governance, which are also evident within clinical and care governance – notably:

- How to balance delivering both a top-down managerial system for providing proactive external assurance in a systematic manner across all teams/services AND enabling a bottom-up mechanism that gives primacy to responsible autonomy across different professionals and disciplines?
- How to deliver visible and public accountability AND the promotion of a "no-blame" learning culture?

For clinical and care governance to work it must be part of the main and routine business of the organization. Care should be taken so that clinical and care governance:

- Does *not* become its own separate bureaucracy.
- Is *not* mistaken as being achieved through the existence of a dedicated committee/meeting.
- Is *not* sidelined as a discrete and insular activity for nominated professional leads.

[6] Scally G, Donaldson LJ. Clinical governance and the drive for quality improvement in the new NHS in England. BMJ 1998; 317:61.
[7] http://www.valeoflevenhospitalinquiry.org/report.aspx

Clinical and Care Governance In West Dunbartonshire Health & Social Care Partnership

While clinical and care governance is a product of structures and processes, how well it is able to deliver genuine benefit service users is highly dependent on the involvement of practitioners/operational staff on the "front line" and how relevant they feel it is to their everyday practice. Given that those individual professionals should appreciate that they are accountable for their individual clinical and care decisions, an effective system of clinical and care governance should be one that stimulates multidisciplinary teams to engage in conversations – in a consistent and systematic manner – that are focused on the detailed composition of care for specific conditions/pathways or patient/client groups[8].

Through the course of 2015/16, a refreshed and over-arching structure has been developed in which to enable structured consideration of and conversations regarding clinical and care governance within WD HSCP. This has been informed by engagement and constructive feedback from management and lead/senior professionals across all disciplines and service areas. This has been agreed by the WD HSCP Chief Officer and Senior Management Team, with a commitment to review and revise as required at the end of 2016/17.

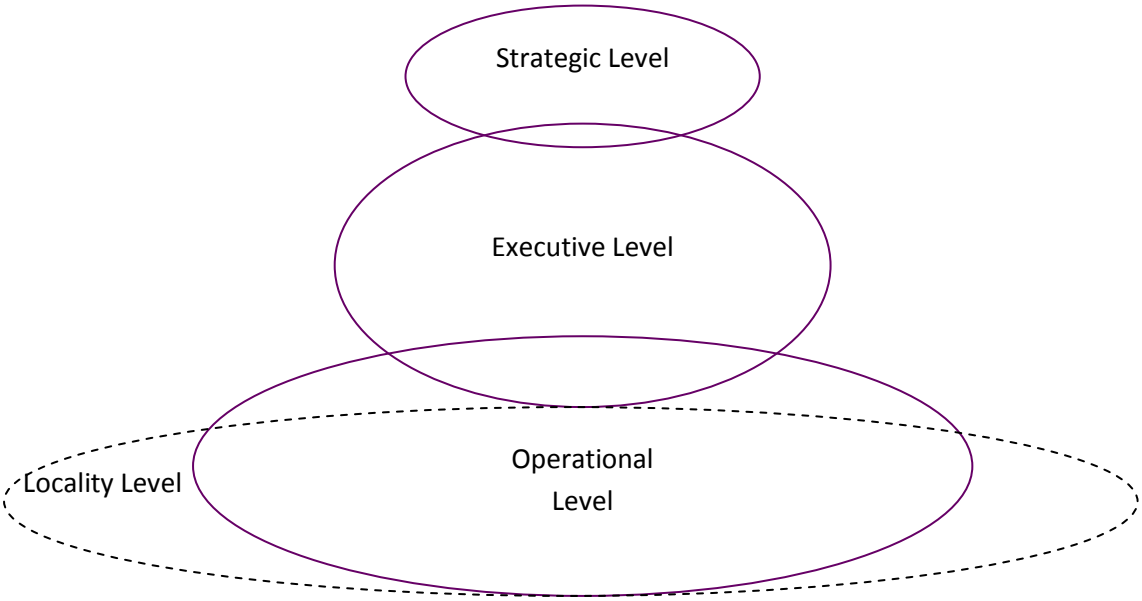
Element 1

A consistent set of agenda items for clinical and care governance for systematic consideration at all levels in relation to the following domains (in a manner most relevant to the level). These domains are drawn and condensed from the previous 7 Pillars:

- Quality Assessment.
- Service User Feedback.
- Staff Governance.
- Risk Management.
- Continuous Improvement.

Element 2

In light of the National Framework, clinical and care governance development will be taken forward across four levels:



[8] Degeling PJ, Maxwell S, Ledema R, Hunter DJ. Making clinical governance work. BMJ 2004; 329(7467): 679–681.

- **Strategic** – i.e. integration authority level.
  Focus - Assurance and scrutiny.
  Mechanism - In addition to performance scrutiny, present and consider:

  - Minutes of Clinical and Care Governance Committee (see below) – HSCP Board.
  - Minutes of Locality Groups – HSCP Board.
  - Minutes of Locality Engagement Networks – HSCP Board.
  - Chief Social Work Officer Report – HSCP Board and Council
  - Clinical Governance Annual Report – HSCP Board and Health Board.
  - Strategic Risk Register – HSCP Board and HSCP Audit Committee.
  - Workforce & Organisational Development Plan – HSCP Board
  - Complaints monitoring report – HSCP Board.
  - External inspection reports – HSCP Audit Committee.

- **Executive** – i.e. chief officer and senior management team level.
  Focus – Providing direction, monitoring and scrutinising.
  Mechanism – local *Clinical and Care Governance Group*, plus support from professional leads.

The following key commitments within the Integration Scheme - as per the legislation - set the core members and parameters for the group (and reflected in its Terms of Reference):

- The Parties will establish a local Clinical and Care Governance Group for integrated services within the Partnership.
- This, when not chaired by the Chief Officer, will report to the Chief Officer; and through the Chief Officer to the Integration Joint Board. Its membership will include the Partnership's Senior Management Team; Clinical Director; Lead Nurse (i.e. Professional Nurse Advisor); Allied Health Professions Lead; and Council's Chief Social Work Officer.
- Through its representative membership, the Clinical and Care Governance Group will interface with the Health Board Clinical Governance Forum; Health Board professional committees; the Area Clinical Forum; Managed Care Networks; and local Multi-Agency Public Protection Arrangement, Adult Support & Protection and Child Protection Committees as appropriate.
- The Chief Officer has delegated responsibilities, through the Parties' Chief Executives, for the professional standards of staff working in integrated services.
- The Chief Officer, relevant lead health professionals and the Council Chief Social Work Officer will work together to ensure appropriate professional standards and leadership.
- The Council and the Health Board will ensure that staff working in integrated services have the appropriate skills and knowledge to provide the appropriate standard of care.
- Partnership managers will manage teams of Health Board employed staff, Council employed staff or a combination of both; and will promote best practice, cohesive working and provide guidance and development to their team. This will include effective staff supervision and implementation of staff support policies. Where groups of staff require professional leadership, this will be provided by the relevant Health Board professional lead or the Council's Chief Social Work Officer as appropriate.
- The Chief Officer will ensure that clear strategic objectives for clinical and care governance are agreed, delivered and reported through an annual clinical and care governance action plan. This will include actions to: *ensure the quality of service delivery* (including that delivered through services procured from the third and independent sector); *address organisational and individual care risks*; *promote continuous improvement*; and ensure that *all professional and clinical standards, legislation and guidance are met*.

The standing agenda for the Clinical and Care Governance Group - the required action plan – will be structured as follows:

- **Quality Assessment** – encompassing performance review; information governance and inspection (including Care Inspectorate assessments of external providers).
- **Risk Management** – encompassing clinical incident, critical incident and significant case reviews and learning.
- **Service User Feedback** – encompassing complaints monitoring and learning.
- **Continuous Improvement** – encompassing all critical self-evaluation activities and learning, plus application of guidance.
- **Staff Governance** – encompassing staff governance framework, registration, revalidation and staff development.

In addition, the agenda will be developed to include:

- A rolling programme of reports from different HSCP operational service areas (one or two per meeting) that considers a particular care issue or client/patient group with respect to each of the five domains above.
- Routine Updates from the Clinical Director on relevant clinical governance matters to highlight from the most recent meetings of each locality group.
- Updates as appropriate on market facilitation engagement with external social care providers in relation to quality assurance and improvement.
- Minutes of the MAPPA; Adult Support and Protection Committee; Child Protection Committee; and Public Protection Chief Officers' Group.

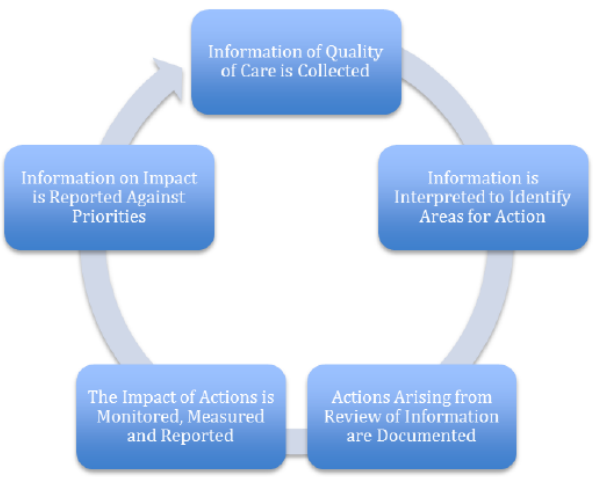
The outputs and learning from all of the above will inform both the Chief Social Work Officer's Annual Report and Clinical Governance Annual Report for then sharing with HSCP Board, Council and Health Board through the appropriate channels.

- **Operational** – i.e. HSCP service level.
  Focus – Critical review, learning and development.
  Mechanism – Integrated into routine team meetings; incident review meetings; learning events/sessions.

  Heads of Service work with professional leads and service managers to identify pro-active activities within the service (including hosted services) that:

  - Address and contribute to the overall HSCP clinical and care governance action plan.
  - High volume or high demand areas of care to be reviewed within the service over the course of the year in relation to the above domains.

    In applying this, service leads and teams would be following the Five Process Steps to Support Clinical and Care Governance described within the National Framework (which is most similar to the Quality Improvement domain), i.e.:



A local *Clinical and Care Governance Forum* will be maintained that brings together the members of the Clinical and Care Governance Group (representing the executive level) and all HSCP service managers/lead professionals (representing the operational level) on a quarterly basis, for the purpose of discussing key quality issues; reflecting on learning; and highlighting good practice.

- **Locality** – i.e. HSCP services and NHS external providers.
  Focus – Promoting critical review, learning and development.
  Mechanism – Within the context of NHS external providers being separately responsible for their own clinical governance (so outwith the accountabilities of the Chief Officer), clinical and care governance would be integrated into routine business of locality group meetings alongside protected learning events/sessions sponsored by the HSCP. Key issues would also be considered in tandem with members of the community (including services users and carers) at Local Engagement Network meetings.

With respect to issues raised and learning generated at either the operational or locality levels, those outputs will be used to inform the content of subsequent Protected Learning Events; and specifically an annual *HSCP Clinical and Care Governance Symposium*, to which all HSCP staff, local NHS external contractors and other relevant stakeholders will be able to participate in and benefit from.

Soumen Sengupta
Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Social Care Partnership
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