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West Dunbartonshire
Health & Social Care Partnership

CLINICAL & CARE GOVERNANCE

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At the end of 2014 Scottish Government published its first unified Framework for **Clinical and Care Governance**.

The Framework states that all aspects of the work of Integration Authorities, Health Boards and Local Authorities should 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.

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The Integration Scheme for West Dunbartonshire emphasises that:

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 those services delegated to the local HSCP Board.

Clinical and care governance 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.

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A recent (September 2015) guidance note* 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.

* Jointly prepared by the Scottish Government's Chief Social Work Adviser and Divisional Clinical Lead – Healthcare Quality and Strategy.

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Clinical Governance – Some Food for Thought

For most of its first four decades, the NHS applied a 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 .

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 .

Prior to 1999, 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 is the mechanism by which that responsibility discharged, placing a statutory responsibility for ensuring quality health care on the chief executives of those organisations.

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

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).

4.Clinical Audit (equivalent to other comparable critical self-evaluation “cycles” of Plan-Do-Study-Act/small tests of change/PSIF/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).

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.

Given more recent events it is important to appreciate:

(1) The on-going relevance of why clinical governance was established in the first place.

(2) 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.

(3) This is equally applicable to social work and social care.

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) are worthy of reflections:

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 Posed By Clinical Governance:

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?

There are no easy or off-the-shelf answers to either in practice.

Delivering clinical and care governance must understood as being the routine business of the organisation.

Care should be taken so that clinical and care governance:

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

Individual professionals should appreciate that they are accountable for their individual clinical and care decisions.

Clinical and care governance is a product of structures and processes …

BUT how well it is able to 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**.

An effective system of clinical and care governance should be one that stimulates multidisciplinary teams to engage in *reflective conversations* – in a consistent, systematic and on-going manner – that are focused on the detailed composition of care for specific conditions/pathways or patient/client groups .

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ARRANGEMENTS FOR WD HSCP

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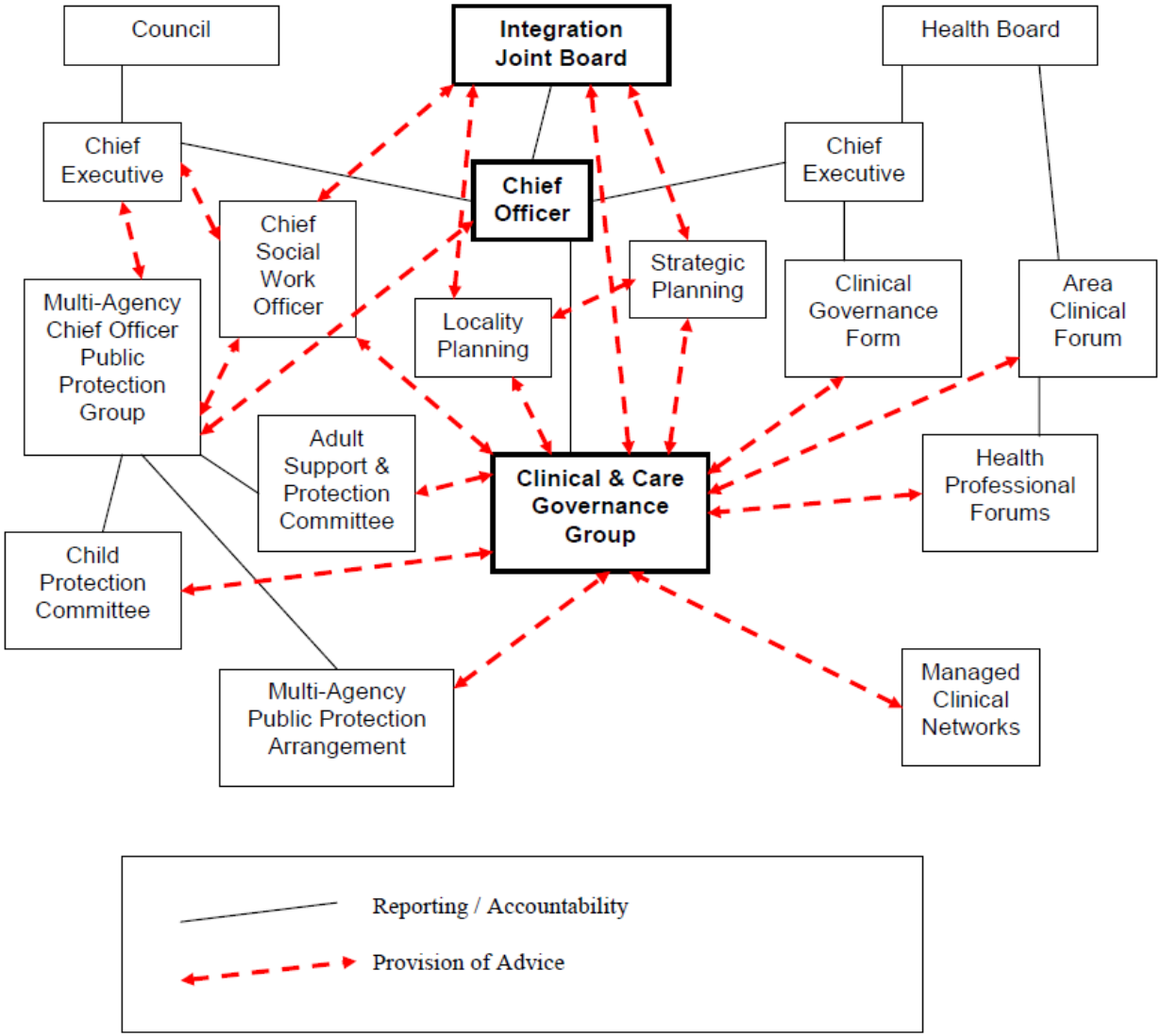

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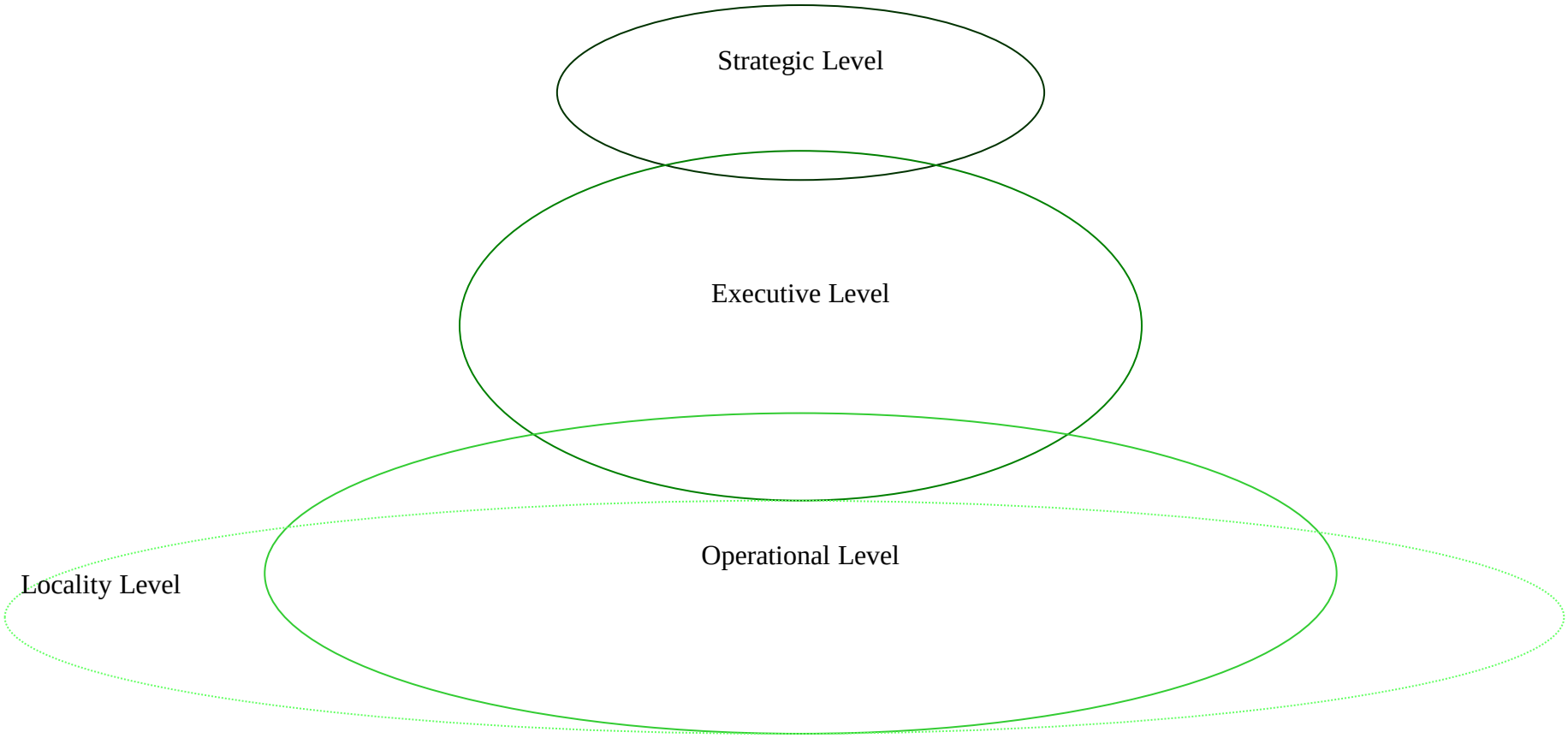
Clinical and Care Governance Arrangements for WD HSCP



Strategic – i.e. integration authority level.
Focus - Assurance and scrutiny.
Mechanism - scrutiny at HSCP Board and Audit Committee.

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

Operational – i.e. HSCP service level.
Focus – Critical review, learning and development.
Primary mechanism – integrated into routine team meetings; incident review meetings; learning events/sessions.

Locality – i.e. HSCP services and NHS external providers.
Focus – Promoting critical review, learning and development.
Primary Mechanism – Within the context of NHS external providers being separately responsible for their own clinical governance, 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.

Executive Level

The refreshed HSCP Clinical & Care Governance Group is:

• Chaired by the Chief Officer, with the Chief Social Work Officer and Clinical Director as Co-Vice Chairs..
• Composed of the Partnership's Senior Management Team; Clinical Director; Professional Nurse Advisor; Allied Health Professions Lead; and Council's Chief Social Work Officer.

Through the Clinical and Care Governance Group, 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.
• Ensure that professional and clinical standards, legislation and guidance are met.

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The HSCP Clinical and Care Governance Group will work in accordance with the National Framework for Clinical and Care Governance, with its remit being to provide direction, monitoring and scrutiny for integrated services in relation to:

- **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.

Operational Level

(1) All team meetings include the following agenda items as routine:

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

(2) 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.

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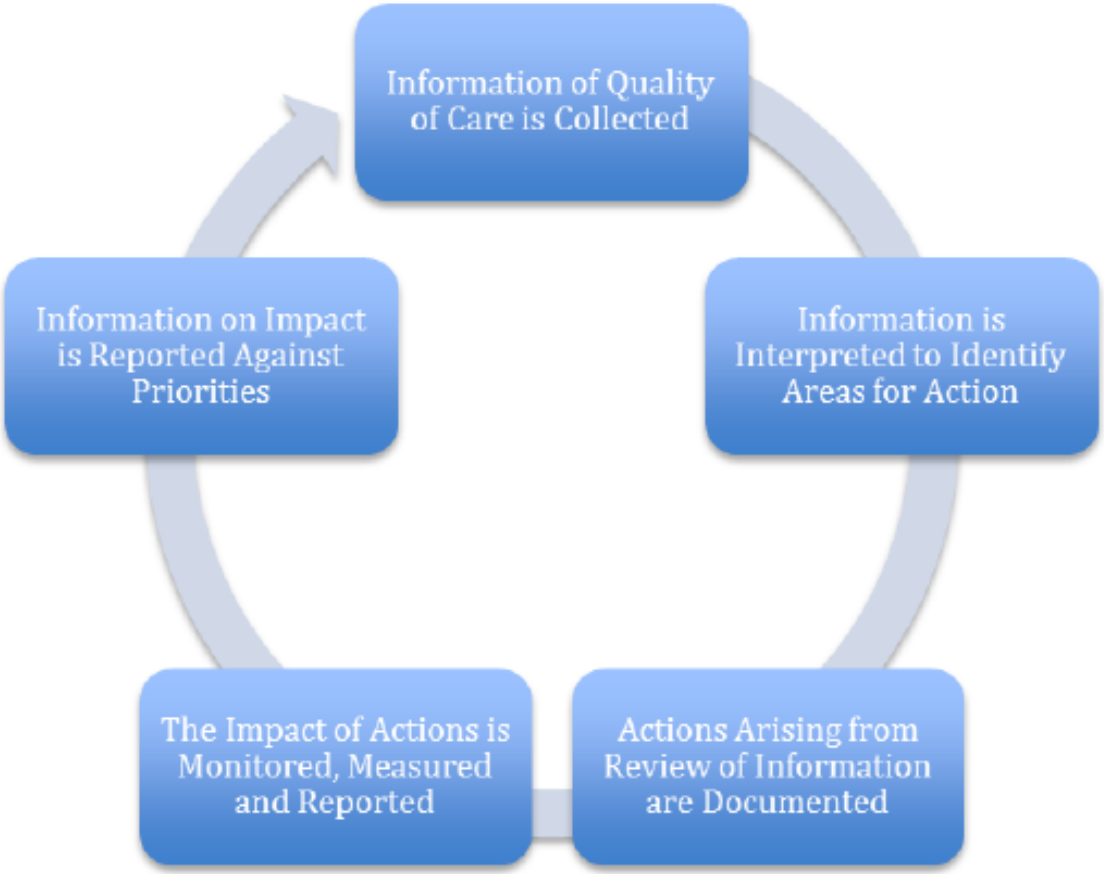
Operational Level

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.:



Fostering Wider Networking, Dialogue and Collective Learning

A local HSCP **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.

An annual HSCP **Clinical and Care Governance Symposium** will be organised that similarly focuses on key quality issue; and to which all HSCP staff, local NHS external contractors and other relevant stakeholders will be able to attend, participate in and sharing learning at.