Guidance Notes for the role of the 'Change Leader'

Introduction

Standards and Guidelines come from a variety of sources and are received by a number of regional bodies for regional endorsement. Such external agencies include the HSC Board, Public Health Agency (PHA) and Safety & Quality Unit at the DHSSPS. These agencies disseminate these standards and guidelines to the HSC Trust's for action and with a requirement that an assurance will be provided to confirm that the required recommendations have been embedded within local practice.

In recent years the volume of standards and guidelines has become increasingly challenging for providers and commissioners to manage within existing risk management and clinical governance arrangements. As a consequence regional discussions have been undertaken to agree the most effective and efficient process for disseminating, implementing and assuring these standards and guidelines.

On 26 September 2011 the Chief Medical Officer issued a circular (reference HSC (SQSD) 04/11) to outline the new processes for the Endorsement, Implementation, Monitoring and Assurance of NICE Guidelines and NICE Technology Appraisals in Northern Ireland. These new processes have come into effect from 28 September 2011. Similarly on 28 September 2011 Dr Carolyn Harper at the PHA issued a draft regional consultation paper which outlined the proposed systematic and integrated approach by these external agencies regarding the issue and management of safety alerts. This was finalised in June 2012.

Role of the Trust's Standards & Guidelines Prioritisation and Risk Review Group

In response to both of these circulars the Trust reviewed it's arrangements for the management of standards and guidelines in February 2012 and as a consequence of this review the Trust's Standards & Guidelines Prioritisation and Risk Review Group has been created. This provides the Trust with a corporate forum that will ensure there is a systematic and integrated approach for the implementation, monitoring and assurance of clinical standards and guidelines. *Appendix 1* of this document provides an outline of the process.

The Trust's S&G Prioritisation and Risk Review Group is chaired by the Mrs Deborah Burns, Assistant Director of Clinical & Social Care Governance and meets on a fortnightly basis. The roles and responsibilities of the group are clearly outlined in the Terms of Reference, which are included in Appendix 2 of this document.

The Role of the Lead Director

Following review by the S&G review group the circular will be sent to the Lead Director along with the completed risk assessment proforma. In order to ensure that the recommendations outlined within any new standard or guideline is embedded within local and current practice there has been a need to nominate a person to take forward the work that is required. This person is referred to as the 'Change Lead' within the Trust's S&G processes. It is the role of the Lead Director to either (i) confirm that the outlined Change Leader is the most suitable person to take forward this work or (ii) if this is not denoted on the risk assessment form then the change lead needs to be nominated.

If a change lead is to be nominated by the Lead Director the Patient Safety & Quality manager must be informed as to who this person is, so that the Trust S&G database can be kept up to date. The Change Lead must also be advised of their nomination in a timely manner and provided with the relevant papers so that the work can be commenced and progressed within the required time scales. In Acute Services the AMD Clinical Standards and Guidelines will be the change lead where the guidance sits across a range of specialties and/or is complex.

The Role of the Clinical / Management Change Leader

Given the newness of these processes and in order to support this person in this role these guidance notes have been developed to outline the key roles and responsibilities that this person will have within the process. The Patient Safety & Quality Manager will also provide a supporting role should there be any queries regarding how best to undertake this work.

Key roles and responsibilities:

1. To review the guidance and (if required) establish and chair a working group to take forward the key recommendations. The working group must be constituted carefully so that there are representatives from all areas to which the guidance is applicable and include members from the multidisciplinary team.

2. Using the Trust's standard action plan proforma ensure that all action plans clearly outline how the recommendations are to be implemented, by whom and when by. If it is identified that there will be significant challenges in complying with these timescales or the actual recommendation itself, it is important that the Change Leader ensures that there is effective and timely escalation to the relevant Director with a clear outline of what the key barriers to implementation are. The lead Director should communicate this information to the Assistant Director of Clinical & Social Care Governance. This will ensure that the S&G review group can review the risk impact for the organisation and if required

(a) Determine if the risk to be placed on the directorate / corporate risk register
(b) Notification can be given to the relevant external agency of the challenges being faced by the organisation

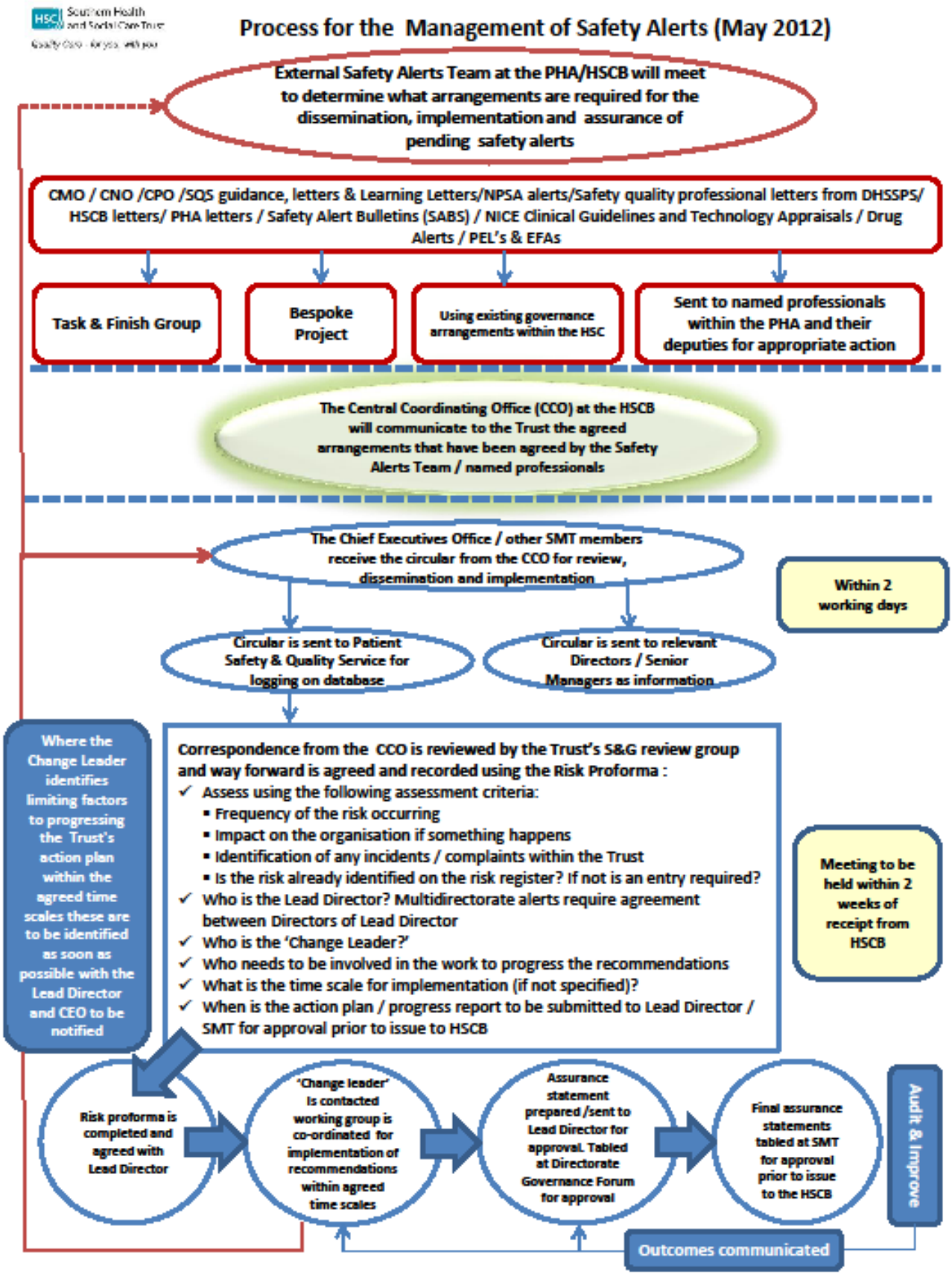
3. Ensure that there is a written record of the work that is being undertaken within the working group so that there is evidence as to how the recommendations are being implemented within the organisation.

4. Ensure that the Patient Safety & Quality Manager is regularly updated on the progress that is being made in regards to compliance levels so that this can be reflected in any reports that are required by the Trust.

Where it is required the Change Leader must provide timely confirmation of the progress that is being made against the required recommendations so that responses to the external agencies can be provided in a timely manner. This will ensure that there has been Lead Director approval prior to final review and approval by the Assistant Director for Clinical & Social Care Governance and if required, the Chief Executive.

Other documents used in developing these Guidance Notes include:

Chief Medical Officer circular (HSC (SQSD) 04/11)
Regional Safety Alerts Protocol (August 2012)


Process for the Management of Safety Alerts (May 2012)
External Safety Alerts Team at the PHA/HSCB will meet to determine what arrangements are required for the dissemination, implementation and assurance of pending safety alerts
CMO / CNO /CPO /SQS guidance, letters & Learning Letters/NPSA alerts/Safety quality professional letters from DHSSPS/ HSCB letters/ PHA letters / Safety Alert Bulletins (SABS) / NICE Clinical Guidelines and Technology Appraisals / Drug Alerts / PEL's & EFAs
Task & Finish Group
Bespoke Project
Using existing governance arrangements within the HSC
Sent to named professionals within the PHA and their deputies for appropriate action
The Central Coordinating Office (CCO) at the HSCB will communicate to the Trust the agreed arrangements that have been agreed by the Safety Alerts Team / named professionals
The Chief Executives Office / other SMT members receive the circular from the CCO for review, dissemination and implementation
Within 2 working days
Circular is sent to Patient Safety & Quality Service for logging on database
Circular is sent to relevant Directors / Senior Managers as information
Where the Change Leader identifies limiting factors to progressing the Trust's action plan within the agreed time scales these are to be identified as soon as possible with the Lead Director and CEO to be notified
Correspondence from the CCO is reviewed by the Trust's S&G review group and way forward is agreed and recorded using the Risk Proforma :
✓ Assess using the following assessment criteria:
▪ Frequency of the risk occurring
▪ Impact on the organisation if something happens
▪ Identification of any incidents / complaints within the Trust
▪ Is the risk already identified on the risk register? If not is an entry required?
✓ Who is the Lead Director? Multidirectorate alerts require agreement between Directors of Lead Director
✓ Who is the 'Change Leader?'
✓ Who needs to be involved in the work to progress the recommendations
✓ What is the time scale for implementation (if not specified)?
✓ When is the action plan / progress report to be submitted to Lead Director / SMT for approval prior to issue to HSCB
Meeting to be held within 2 weeks of receipt from HSCB
Risk proforma is completed and agreed with Lead Director
'Change leader' is contacted working group is co-ordinated for implementation of recommendations within agreed time scales
Assurance statement prepared /sent to Lead Director for approval. Tabled at Directorate Governance Forum for approval
Final assurance statements tabled at SMT for approval prior to issue to the HSCB
Audit & Improve
Outcomes communicated

Trust Standards & Guidelines Prioritisation and Risk Review Group

Terms of Reference

Introduction

Standards and Guidelines come from a variety of sources and are received by a number of regional bodies for regional endorsement. Such external agencies include the HSC Board, Public Health Agency (PHA) and Safety & Quality Unit at the DHSSPS. These agencies disseminate these standards and guidelines to the HSC Trust's for action and with a requirement that an assurance will be provided to confirm that the required recommendations have been embedded within local practice.

In recent years the volume of standards and guidelines has become increasingly challenging for providers and commissioners to manage within existing risk management and clinical governance arrangements. As a consequence regional discussions have been undertaken to agree the most effective and efficient process for disseminating, implementing and assuring these standards and guidelines.

On 26 September 2011 the Chief Medical Officer issued a circular (reference HSC (SQSD) 04/11) to outline the new processes for the Endorsement, Implementation, Monitoring and Assurance of NICE Guidelines and NICE Technology Appraisals in Northern Ireland. These new processes have come into effect from 28 September 2011 (*Appendix 1*).

On 28 September 2011 Dr Carolyn Harper at the PHA issued a draft regional consultation paper which outlined the proposed systematic and integrated approach by these external agencies regarding the issue and management of safety alerts (*Appendix 2*).

In response to both of these circulars the Trust has reviewed it's arrangements for the management of standards and guidelines and as a consequence of this review the Trust's Standards & Guidelines Prioritisation and Risk Review Group has been created. The inaugural meeting of this group is scheduled for 19 April 2012.

Aim

The aim of this group is to provide a forum to ensure that the Trust has in place a systematic and integrated approach for the implementation, monitoring and assurance of clinical standards and guidelines.

Scope

The Trust's Standards & Guidelines Prioritisation and Risk Review Group will review the following standards and guidelines within it's fortnightly meetings:

- Chief Medical Officer Circulars
- Chief Nursing Officer Circulars
- CaNNI reports
- CMACE
- Drug Alerts
- GAIN reports
- HSCB / PHA communications
- NCEPOD reports
- NPSA alerts
- NICE (Clinical Guidelines and Technology Appraisals)
- Policy Circulars – S&Q Learning Communications
- RQIA reports
- SABS Alerts
- Professional Estates Letters / Estate & Facility Alerts

Key Performance Indicators

5. To ensure that there is a process in place to ensure that all regionally endorsed standards and guidelines are formally logged on the Trust's Standards & Guidelines database and reviewed in a timely manner at the Trust's Standards and Guidelines Prioritisation and Risk Review group. This group will meet on a fortnightly basis.

6. To ensure that all regionally endorsed standards and guidelines work streams are prioritised in line with other competing governance requirements. This process of prioritisation will be based on the following:
   a. Collaborative discussions by all of the group members who will be responsible for reviewing the issued standards and guidelines seeking expert opinion from within their own areas of responsibility.

b. Cognisance of organisational intelligence that has been identified by other governance and risk management processes (i.e. lessons learned from complaints / serious adverse incidents / litigation)

c. Cognisance of the challenging timescales that are being externally driven by regional bodies such as the Safety & Quality Unit at the DHSSPS, HSC Board, Public Health Agency etc.

7. Using the Trust's approved risk assessment proforma, review all new standards & guidelines to determine the following:
   - ✓ Frequency of the risk occurring
   - ✓ Impact on the organisation if something happens
   - ✓ Identification of any incidents / complaints within the Trust
   - ✓ Ascertain if the risk already identified on the risk register and assess if an entry is required?

8. Identification of the Lead Director and if there is a multi-directorate applicability seek agreement between Directors of Lead Directors as to who will take forward the role.

9. Identification of a suitable 'Change Leader' and ensure the communication processes are in place to ensure that the required actions are taken forward within a co-ordinated and time managed process

10. Seek agreement of the time scale for implementation (if not already specified).

11. Outlined the monitoring arrangements that are required so to ensure that the action plan / progress report is submitted to Lead Director / SMT for approval prior to issue to HSCB.

12. Ensure that there are good record keeping processes in place to provide written assurances that processes are embedded within the organisation and appropriate action is being taken.

13. Ensure that there are effective escalation processes in place should concerns be raised about the Trust's ability to achieve full compliance.

14. Ensure that there is on-going monitoring of the Trust's Accountability Report for Standards & Guidelines in order to ensure that progress against safety alert recommendations is monitored on an on-going basis. If it is identified that there has been a lack of progress or if there are challenges / barriers to gaining full compliance this must be escalated to the relevant Director / Senior Management Team for review.

Group Constitution:

The Trust Standards & Guidelines Prioritisation and Risk Review Group will be composed of the following members:

- Assistant Director for Clinical & Social Care Governance (*chairperson*)
- Medical Director / Senior Manager within the Medical Directorate
- Governance Co-ordinator - Acute Services
- Governance Co-ordinator - Children's & Young Peoples Service
- Governance Co-ordinator - Mental Health & Disability
- Governance Co-ordinator - Older People & Primary Care Services
- Medicines Governance Pharmacist
- Patient Safety & Quality Manager
- Estates Risk & Governance Manager

The membership the Committee will be chaired by the Assistant Director of Clinical & Social Care Governance. Invitations may be extended to other Trust members or outside agencies if deemed appropriate by the group members and will be facilitated by the chairperson.

Responsibilities of Group Members

- ✓ Each member will be responsible for reviewing the issued standards and guidelines and seeking expert opinion from within their own areas of responsibility and for representing this view as appropriate.
- ✓ Following each meeting the Governance Co-ordinators will be responsible for reporting the meeting outcomes back to their Director.
- ✓ The Chairperson will be responsible for providing regular summary reports to SMT and to the Trust's Governance Working Body.

Quorum & Meeting Frequency

A meeting will be quorate if five members are present. If members cannot attend, they will be expected to send an appropriate deputy.

The committee will meet on a fortnightly basis and to facilitate diary management will be held on the relevant Thursday at 12pm (unless otherwise indicated). However arrangements will be put in place to ensure that any immediate issues that need to be addressed are processed immediately.

Management of the Steering Group Meetings

An agenda and required papers will be issued on the Monday of the planned meeting week so to ensure timely review and preparation for the meeting.

Review of the Terms of Reference

The terms of reference will be reviewed on an annual basis or earlier if required.