Altnagelvin Hospitals
Health and Social Services Trust

Clinical and Social Care Governance Report

from 1 April 2002 - 31 March 2003

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FOREWORD

This, our first published, Annual Report of the Clinical and Social Care Governance Committee, marks an important milestone in the history of health and social care in our Trust and in Northern Ireland.

The statutory duty of quality is an onerous responsibility, which we believe can assist us as we improve our services whilst demonstrating our accountability for the assurance of quality of diagnosis, care and treatment.

This Report provides information on our progress along the Clinical Governance journey for the year past and presents targets for the year to come.

We are committed to the pursuit of clinical excellence and continue to develop ways of ensuring that we are an active and learning organisation in pursuit of that excellence.

The Report is commended as an important starting point in our development and as a useful source of reference for our public. A shared understanding and local ownership of clinical governance will be essential components of the continued successful implementation of this important quality standard.

Denis Desmond
Chairman Clinical and Social Care Governance Committee

Section 1
CLINICAL AND SOCIAL CARE GOVERNANCE

1.1 INTRODUCTION

Clinical Governance has been defined as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.." (A First Class Service 1998). Under the term clinical governance NHS Trusts have had a duty, since 1998, of ensuring the clinical quality of the services they provide. Clinical and Social Care Governance became a statutory responsibility for Trusts in Northern Ireland from April 2003.

Clinical Governance encompasses all the processes needed to achieve the highest quality clinical practice possible within available resources. It builds on the good and effective systems already in place and is based on a system of learning from mistakes in order to improve care in the future.

In Northern Ireland Circular HSS(PPM) 10/2002 was launched in January 2003 Governance in the HPSS – *Clinical and Social Care Governance: Guidelines for Implementation.*

This guidance enabled the Trust to formally begin the process of developing and implementing clinical and social care governance arrangements within Altnagelvin. It was considered in conjunction with guidance issued on the implementation of a common system of risk management across the HPSS and the development of controls assurance standards for financial and organisational aspects of governance.

Altnagelvin Health & Social Services Trust developed and implemented a strategy for delivering quality. The report provides details on the activities undertaken and those planned for the future, in the areas of Risk Management, Clinical Effectiveness, and Education and Training. It also outlines the accountability and assurance structures within the Trust for Clinical and Social Care Governance.

The success in addressing the quality agenda will be in the way in which we are able to make it a part of everyone's job.

1.2 LEADERSHIP AND ACCOUNTABILITY

Clinical and Social Care Governance now places a statutory responsibility on Trusts for the quality of their services. Chief Executives will be held accountable for this. Arrangements have been put in place in Altnagelvin to enable the Chief Executive to discharge this responsibility and for the Trust Board to be assured of this.

Within Altnagelvin Health & Social Services Trust, the Director of Nursing and the Medical Director have been charged with the responsibility to put in place the necessary arrangements to implement the requirements of Clinical and Social Care Governance. They have also been delegated joint lead roles for Clinical and Social Care Governance within the Trust.

A Clinical Governance Steering Group was established in 2001 to examine the requirements of this duty of quality and to develop a Clinical and Social Care Governance Strategy for the Trust. The Strategy clarified the assurance and accountability arrangements emphasising that each clinical professional is accountable for the quality of the services he/she provides. This process is managed within the normal management arrangements of the Trust. Within the individual Directorates accountability rests with the Clinical Director.

The Clinical Director meets with members of Hospital Executive, (i.e. the Deputy Chief Executive and Director of Business Services, Medical Director, Director of Nursing, Directors of Finance and Personnel), in a Business planning and Accountability meeting three times per year where Clinical and Social Care Governance forms a main item on the agenda.

The assurance systems are delivered through the Risk Management & Standards Committee and Clinical and Social Care Governance Committee to Trust Board. (See appendix 1)

1.3 CLINICAL GOVERNANCE COMMITTEE

The Clinical and Social Care Governance Committee, which is directly accountable to Trust Board, is chaired by Mr D Desmond, Chairman of the Trust. This committee has formally met and agreed the following:

- Membership
- Terms of reference
- Information Requirements
- Development of a User Involvement Strategy
- Schedule of meetings

(See appendix 2)

1.4 RISK MANAGEMENT AND STANDARDS COMMITTEE

The Risk Management and Standards Committee is chaired by the Trust's Medical Director. The role of this committee is to provide assurance to the Clinical Governance Committee that appropriate mechanisms are in place throughout the organisation for managing risk. This committee has formally met and agreed the following:

- Membership
- Terms of Reference
- Information Requirements
- Schedule of Meetings

(See appendix 3)

1.5 SUB COMMITTEES

It has been agreed by the Clinical Governance Committee that a number of forums should become sub committees of the Risk Management and Standards Committee. The titles of these sub committees are detailed below:

- Clinical Audit
- Infection Control
- Drug and Therapeutics
- Clinical Claims
- Local Medicine Governance
- Health & Safety
- Near patient testing
- Clinical Incidents
- Blood Transfusion

These sub committees will assist the Trust in assuring it is meeting its requirements under the clinical governance legislation.

The Risk Management and Standards Committee have asked chairs of each sub committee to highlight key risks in their area of expertise. Minutes of sub committee meetings are also required to be submitted to the Risk Management and Standards Committee.

Section 2
CLINICAL EFFECTIVENESS

2.1 INTRODUCTION

Clinical Effectiveness can be described as: -

Doing the right thing
For the right patient
In the right way
At the right time
At the right cost

(NHS Executive 1995 EL 95105)

There are several key building blocks to achieving clinically effective care in the H&PSS. These include clinical audit, research, standards and guidelines, care pathways, clinical risk management, complaints monitoring and practice developments. The clinical effectiveness team in Altnagelvin Hospitals Trust are focused on several of these activities, which are described in the following pages. To support staff in developing aspects of their clinical practice the Trust has appointed a Practice Development Nurse on a temporary contract to begin setting some structures in place.

2.2 CLINICAL AUDIT

Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.
(National Institute for Clinical Excellence)

Society has increasingly questioned quality of care and concepts of professional discretion or clinical freedom.

The evidence of this shift in public thinking is shown in the demands of pressure groups, press coverage, calls for public inquiries, and the rise of complaints, legal challenges and claims for redress.

If done well, clinical audit can provide a way in which the quality of the care provided can be reviewed objectively, within an approach that is supportive and developmental.

The Clinical Audit department has two main functions: -

1. The promotion of audit across the hospital community and the undertaking of multi-professional hospital wide audit activity. The impetus for this hospital wide audit work comes from reports such as complaints monitoring, clinical incidents or quality framework documents such as CREST publications. To date the clinical audit department has been involved in several hospital wide audits, including patient documentation, and the management of blood transfusions throughout the Trust. Future plans for hospital wide audit include auditing the privacy and dignity we provide for our patients and examining the standard of nutrition and diet we offer patients whilst in hospital.

2. Supporting individual staff and/or clinical teams undertaking audit work. Each Directorate within the Trust is responsible for identifying their own audit agenda. The audit department will provide support ranging from retrieval of patients' notes, collecting the data, preparing presentations and writing the final report.

The audit department is also responsible for hosting the Annual Audit, Quality and Research Symposium. This Symposium is the opportunity for Hospital staff involved in audit, quality, and research activity during the year to present their findings. It is also a learning opportunity for new staff to appreciate the value of clinical audit. Prizes are awarded for each of the above categories.

A breakdown of the total number of Audits involving the Clinical Audit Department are outlined in the table below.

	Total
AUDITS	77
CASENOTES PULLED	3,148
NATIONAL AUDITS = 3	• National Caesarean Section Audit • National Stroke Audit • Blood Transfusion Audit
REGIONAL AUDITS = 8	• Hepatitis C Audit • Foeto-Maternal Alloimmune • Thrombocytopenic Audit • Thrombolysis Audit • Breast Care Outcomes Audit • Malignant Spinal Cord Compression Audit • Complications of Chemotherapy Audit • Palliative Care • Delays in Discharge Audit • Low Fragility Audit

It is well documented that the interpersonal aspects of health care are seldom evaluated although their importance is unequivocal. The views and experiences of the people who use the Health Service should form an important element of any assessment of its performance. The HOSQIP programme offers departments within the hospital the opportunity to put in place a range of quality initiatives designed to improve the Patient's experience of care. Some examples of work undertaken during the year are:

- Reducing noise levels on Wards at night
- Patient Satisfaction Surveys
- Nutrition of Patients
- Refurbishing the garden areas for ambulatory patients
- Information leaflets for patients
- Charter Mark for Maternity Services
- UNICEF Baby Friendly Hospital award for Breast Feeding

2.3 PRACTICE DEVELOPMENT

2.3.1 Guidelines and standards

Guidelines and standards have been described as: -

> 'systematically developed statements to assist the health care worker in making patient decisions about the appropriate health care for specific patient groups'.

There are many guidelines and standards issued from different organisations such as NICE and CREST. Clinical audit is one way of measuring adherence to such guidelines and standards. For guidelines, which are generated, internally there is Trust guidance available to ensure that they meet an acceptable standard.

2.3.2 Integrated Care Pathways

A clinical tool, which seeks to ensure that care given to patients is based on evidence, is known as an Integrated Care Pathway. The development and subsequent use of integrated care pathways is another means of assuring the quality of the patients' care in the Trust. Work is underway in the Orthopaedic Department, Day Case Surgery and Dermatology to develop integrated care pathways to ensure patients receive evidence based clinical care. The development of care pathways also provides an integrated clinical record to chart the care and progress of individual patients undergoing certain procedures and investigations.

2.3.3 Clinical Supervision

Clinical Supervision is seen as a supportive mechanism for staff and as such provides staff an opportunity to review, with an experienced mentor, their individual working practices and to reflect on how they could change or improve the care they deliver.

Following a major staff survey work is ongoing in different departments throughout the Trust exploring the best way of providing such support for staff members.

2.3.4 Nursing Documentation

A working group has been set up within the Trust to take forward the issues arising out of the hospital wide documentation group. Each ward in the Trust is represented on this group and members will be responsible for ensuring that the deficits and problems in and with nursing documentation will be addressed. This group has already

addressed nursing documentation in relation to monitoring vital signs, managing fluid balance, recording patients' care post operatively and are currently reviewing the nursing assessments that are undertaken at ward level. This group is addressing fundamental patient management issues for nursing and as such will be working hard to improve the assessments nurses engage in when establishing patient management plans.

2.3.5 Tissue Viability

Tissue viability is concerned with the management of patients' skin and wounds while they are in hospital undergoing care. The role of the Tissue Viability Nurse is about :-

- Risk management and prevention of problems
- Clinically effective practice
- Education and training
- Nurse led clinics
- Resource management
- Audit and research
- Development of policies and protocols in relation to tissue viability

Currently the Trust employs one Tissue Viability Nurse who, along with a group of Wound Link Nurses, leads and provides the wound care service for the Trust. This involves nurse led clinics in leg ulcer care, general wound care and diabetic foot ulcer care.

The Trust has a practice development partnership with the University of Ulster and has been jointly involved in a number of research projects

in tissue viability. The Trust has been involved in several research opportunities, which include a Randomised Control Trial into the Use of Low Intensity Laser, the Selection of Pressure Relieving Equipment. The results of these projects have been published in reputable wound care journals. A third publication has been achieved following an audit project into the correct method of wound swabbing.

The Trust has entered into partnership with Cochrane Wounds Research Group and will be participating in a UK wide study into the use of maggots in leg ulcer care. The Trust has participated in a European wide study into the development of pressure sores. The Tissue Viability Nurse has been involved in peer reviewing articles for publication and has contributed a chapter in a book entitled Wound Care Issues, which was published one year ago.

Education and Training

The Trust has valued staff development and has invested in training programmes for staff in the specialty of wound care. Twenty Wound Link Nurses have been involved in training to Degree level in aspects of tissue viability and the Tissue Viability Nurse has a post-graduate qualification in this field of work.

Policies and Guidance

A range of policy documents has been developed for the Trust which include:-

- Prevention and Management of Pressure Sores
- The Correct Method of Wound Swabbing
- Management of Leg Ulcers
- Selecting a Pressure Relieving Mattress
- The Correct Use of Sterile Maggots in Wound Care

Audit and Quality

There is an ongoing monthly monitoring programme throughout the Trust in relation to the prevalence and incidence of pressure sores. The reports are then used as a basis to teach and train staff in matters relating to pressure sores.

2.4 RESEARCH

Research and development is an integral part of clinical governance. Research is associated with the generation of new, and testing of existing knowledge and is fundamentally pivotal to the successful promotion and provision of modern, effective health and social care services.

Within Altnagelvin Trust the Ethics Committee governs approval for research.

Ethics Committee

The committee is authorised by the Trust :

a. To require all proposals for research or clinical trials affecting patients to be submitted to the Committee for approval prior to their commencement within the Trust.

b. To consider general ethical issues, which arise from the normal provision of services to patients either, referred by members of staff or members of the Committee.

c. To consider ethical implications for the Trust of developments and advances in the field of medicine and evolving changes in the application of the law in health and social care setting.

d. To advise the Trust on the issue of guidance to staff who may be faced with such ethical problems.

e. To obtain independent professional or outside legal advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

During 2002/2003 the Ethics Committee met on 3 occasions and approved 26 studies. This consisted 13 local studies and 13 multi-centre studies. The local studies were conducted by a range of professions including Medical, Nursing, Midwifery, Radiography and Medical Technical Staff.

Section 3.
RISK MANAGEMENT

3.1 INTRODUCTION

Risk management is a process, which identifies, measures and controls activities, which put patients, employees and others at risk. It aims to eliminate or reduce those risks with a consequent improvement in patient care, staff well being and Trust reputation.

Altnagelvin Hospitals Trust recognises that risk management should be an integral part of the organisation's culture and become the business of everyone in the organisation. The Trust has made significant progress in the development of risk management by seeking to develop a risk management culture across all Directorates.

Risk Management is central to the Clinical Governance agenda and will provide the focus for identifying where practices and activities are less than optimal. Once identified, weaknesses can be addressed and acted upon. This will ensure that high quality, effective treatment and care is delivered and that where things do go wrong they are quickly addressed and lessons are learnt to help prevent re-occurrence.

In March 2002 Altnagelvin Trust introduced a computerised risk management system. The system has 5 modules :- complaints, accidents, incidents, claims and a risk register. The information will assist the Trust to identify and prioritise key risks and will help inform the Trust wide Risk Register, enabling the Trust to develop action plans to reduce risk to patients and the organisation itself.

3.2 CLINICAL RISK

Risk Management can be viewed as an essential quality system and one, which is a fundamental part of a total approach to quality improvement. It brings with it quality benefits to the whole range of services being provided by the Trust. A major component of the management of clinical risk is an agreed system for the reporting of clinically related patient incidents.

3.2.1 Clinical Incidents

Incident reporting offers a framework for the detection of untoward incidents and near misses, which enables action to be taken, lessons to be learnt, practices to be reviewed and improved and information to be shared to prevent any recurrence.

A Clinical Incident reporting system was launched by the Trust in February 2000 and it is already providing information, which can be acted upon to improve patient care. All specialties are encouraged to report any incident which has a potential or actual adverse clinical outcome, not expected to occur in the routine course of clinical events.

In the year from 1st April to 31st March 2003, 41,249 patients were treated as inpatient and day cases. There were 339 Clinical Incidents reported. This equates to 0.82% of patient activity. None of the incidents resulted in serious harm or injury to patients.

In August 2002 the Department of Health funded a medicines governance project to focus on the reporting and reviewing of medication incidents. The Trust actively encourages staff within this Trust to report medication incidents so that the lessons learnt can be shared throughout Northern Ireland.

The medicines governance Pharmacist within Altnagelvin Hospital works in close liaison with the Risk Management Department to address issues identified from Clinical Incidents. 10% of clinical incidents reported within the year April to March 2003 related to medication.

Within the Women and Children's Directorate, the Obstetrics and Gynecology specialties have agreed lists of reportable events recommended by their Professional Bodies and an Obstetric Risk Management Committee has been established to review issues identified from reportable events. Within the past year the Committee have made a number of recommendations for audit, improved guidelines and improvements in practice.

3.2.2 Clinical Negligence Claims

Regrettably, on occasions, patients feel that the treatment they have received does not meet the standard they expected and as a result they proceed to take the matter to litigation. The Trust harnesses the information gained as a result of the claims process and ensures that lessons learnt are disseminated throughout the organisation.

As at 1st April 2002 the Trust had 185 outstanding clinical negligence claims. In the year to 31st March 2003, 44 new claims were received, 11 were withdrawn and 13 were settled.

In addition to the valuable information that can be obtained from litigation, complaints and incidents it is essential that Clinicians constantly review their practice to identify clinical risks that can be acted upon to improve patient care.

3.2.3 Complaints/Commendations

In 2002/2003 the Patient's Advocate Office received 200 complaints from 155 complainants.

There were 189 enquiries and 3,030 commendations in relation to services provided by the Trust.

During the year there were six requests to the Convenor of the Western Health and Social Services Board for Independent Review. The six requests were not referred to a Panel.

COMPLAINTS PROCEDURE

A complaint can be made to any member of staff or by contacting the Patient's Advocate, Ground Floor, Altnagelvin Area Hospital, Glenshane Road, Londonderry, BT47 6SB. Telephone [redacted].

Complaints are acknowledged in writing within two working days. During the year 2002/2003, 172 complaints were responded to in 20 working days and 28 complaints were responded to in more than 20 working days.

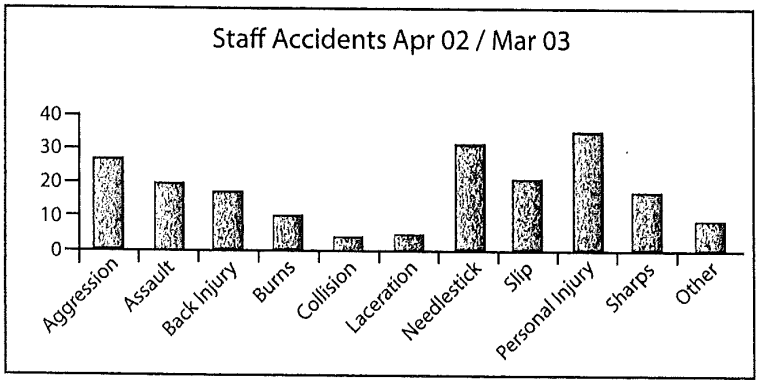
COMPLAINTS BY CATEGORY

Subject	No.	Subject	No.
Access to premises	1	Hotel / support / security	8
Access to records	2	Other	23
Admission delay / cancellation (patient)	3	Patients Privacy & Dignity	2
Aids, adaptions & appliances	1	Patients Status, discrimination	1
Appointments, delay / cancellation (outpatient)	15	Policy & Commercial decisions	1
Clinical Diagnosis	8	Professional Assessment	2
Communication / information to patients	28	Staff attitude	34
Confidentiality	3	Treatment & Care (Quality)	42
Consent to treatment	1	Waiting Times (Outpatients)	6
Discharge & Transfer arrangements	6	Waiting Times (A. & E.)	13

3.3 NON CLINICAL RISK/HEALTH AND SAFETY

The Health and Safety at Work Order is the primary legislation covering the requirement of employers to provide, as far as is reasonably practicable, a safe environment for their employees. Altnagelvin Hospitals Health and Social Services Trust takes its responsibilities in relation to Health and Safety very seriously. Accident reporting can provide the Trust with valuable information on where to focus attention to improve Health and Safety of Staff, Patients and Visitors. The information system assists in identifying trends and areas for improvement.

In the year to 31st March 2003 193 staff accidents were reported. This equated to 8.5% of the staff employed.



The data indicates that the areas for attention are Back Injuries, Aggression and Assault, and Needle Stick Injuries.

Aggression and Assault

In January 2002 the Trust commissioned an external company to undertake a risk assessment in relation to violence in A&E. A project board and project team was established and the team was charged with the task of implementing the recommendations within a 6-month time scale. The key recommendations related to improvements in Environment, Staff Training and Security.

Back Injury

In October 2002, the Trust appointed for a 2-year period an Ergonomic Assessor to address back care problems amongst Hospital Staff. Within the initial 6 months the Assessor has treated 90 staff. Over 95% of referrals have been able to remain at work. 15% of long-term absentees have returned to work under supervision and on the job assessment has changed work practices in a number of areas.

Needle stick Injuries

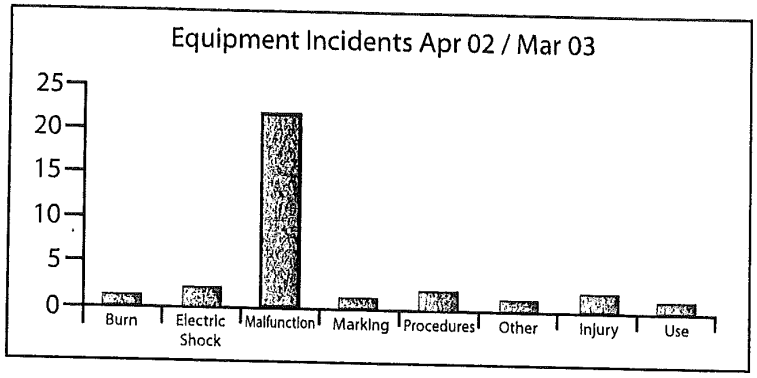
A high profile campaign to remind staff of the safe disposal of sharps was undertaken throughout the year. In addition, on receipt of an incident involving a sharp, a risk assessment is undertaken to look at the system in the individual area to identify any failures in procedures.

Equipment Incidents

Whenever medical devices are used it is important that they are suitable for their purpose and maintained in a safe and reliable condition. Altnagelvin Trust has systems in place to ensure the safe and effective use of devices.

The Northern Ireland Adverse Incident Centre (NIAIC) requires Trusts to report equipment incidents to ensure that when defects are noted the information can be shared with users of equipment throughout Northern Ireland. Altnagelvin Trust actively encourages staff to report equipment incidents to the Trust. The Trust's Technical Equipment Manager acts as the reporting Officer to the NIAIC.

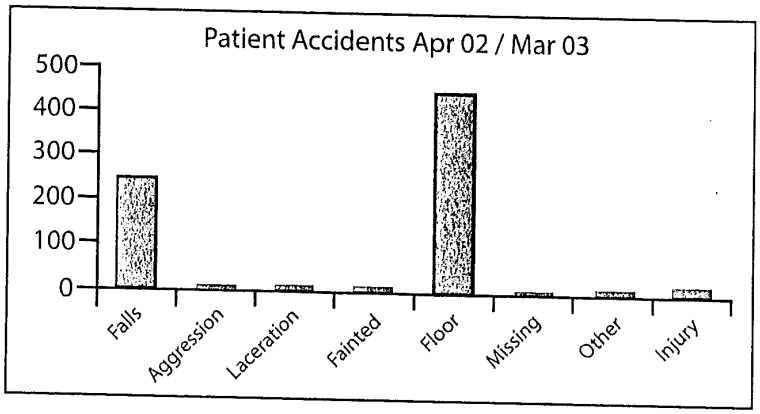
In the year to 31st March 2003 there were 31 equipment incidents reported. Each incident is investigated by the Trust and necessary action is undertaken.



Staff are encouraged to report any incident involving a patient, to provide the Trust with an indication of the areas of risk associated with their care.

Patient Accidents

In the year to 31-3-03 there were 777 patient accidents reported which equated to 1.9% of patient activity.



The two highest categories of accidents involving patients are Patient Falls and Patients Found on the Floor. In an effort to address the number of falls involving patients, the Trust established a Falls Group in 2000, and they designed a falls risk assessment for use within the Trust. A number of control measures were put in place, in particular for some vulnerable patients specialist alert equipment was purchased. It is proposed to re-establish the Trust Falls Group in the coming year to review the systems in place and to make recommendations for reducing falls.

3.3.1 Risk Assessment

Under the guidance of the Risk Management Department risk assessments have been successfully completed and risk assessors have been nominated in individual wards/departments. Risk Assessments are currently being reviewed and the Risk Management Director and the Risk Management Project Sister provides guidance and assistance to staff on a range of Health and Safety issues. The Health and Safety Annual Report provides details of Health and Safety activities undertaken throughout the year.

3.3.2 Decontamination

In 2002 the Department of Health asked Trusts to undertake an audit of Decontamination practices. Altnagelvin Hospitals established a Decontamination Committee and compiled an action plan to address any shortfalls in practices. The process is still ongoing led by the Project Sister, assisted by Estates Services. In future the recently appointed Medical Engineer will be required to co-ordinate the process and to provide the Risk Management and Standards Committee and Clinical and Social Care Governance Committee with an annual report providing assurance on compliance with Department of Health's Decontamination guidelines by 31st March 2004.

3.4 Risk Register

Individual Directorates, Wards and Departments will be encouraged to prioritise their risks. An organisation wide risk register will be developed to ensure that significant risks are recorded, actions identified and implementation tracked. The Risk Register will be a working document identifying major risks for the Trust. The Risk Management and Standards Committee will use the document to inform the Clinical Governance Committee of the action required to control these major risks to ensure that the Trust can meet its business objectives.

The key risks for Altnagelvin are:

- Clinical
- Health and Safety
- Estates and Environment Risks
- Financial Risks

3.5 Controls Assurance

Controls assurance is essentially a process that will enable HPSS organisations to provide evidence that they are doing their reasonable best to manage themselves so as to meet their objectives and protect patients, staff, public and other stakeholders against risks of all kinds. Chief Executives, as accountable officers, are required to report on this issue to the Department of Health Social Services and Public Safety.

Controls assurance was first introduced to the NHS in 1999. The DHSSPS are currently working towards developing standards for Northern Ireland. It is anticipated that Trusts will be asked over the coming year to focus on 7 areas for auditing - these are:

- Financial Management
- Governance
- Risk Management (core standard)
- Medicines Management
- Human Resources
- Medical Equipment and Devices
- Records Management

Although not a specific requirement on Northern Ireland Trusts, Altnagelvin Hospitals Trust has undertaken audits against the UK Controls Assurance Standards in Infection Control, Equipment Management and Risk Management. The completion of these audits has enabled recommendations and action plans to be put forward to Hospital Executive, (Senior Management Team) which will ensure that the Trust can focus attention on any deficiencies identified by the Standards.

Section 4.
EDUCATION AND TRAINING

"It is the education and training received by professional staff that will determine to a very large extent the quality of service provided. It is the application of their education and training in the clinical setting that is fundamental". (Lugon et al 1999). Through the staff appraisal system the individual training needs of clinical professionals are identified and the Trust is committed to ensuring that where possible these training needs are met.

4.1 North & West In-Service Education Consortium

In this first Clinical Governance report only one aspect of the training is reported on relating to Nursing Staff and the training by the North and West In-service Education Consortium. In future reports Medical and Allied Health Profession Training will also be addressed.

The North and West In-Service Education Consortium, recognises that continuing professional education is essential for Nurses, Midwives and Health Visitors in order to ensure their ability to be accountable for their quality of care to patients and clients. Therefore, to provide high quality in-service education programmes that will enhance nursing care, disseminate nursing knowledge and promote evidence based practice, each year the Consortium conducts a training needs analysis where it seeks to listen and discuss with practitioners and managers, their professional in-service education needs and aspirations.

During the period 1 April 2002 – 31 March 2003, the Consortium delivered to Altnagelvin Hospitals Trust, a wide variety of in-service programmes primarily for nursing staff and the attendance figures for this period totalled almost 700. With specific reference to the Clinical

and Social Care Governance agenda, it was pleasing to note that the following programmes received favourable support:-

- Manual Handling
- Legal Aspects in Nursing Practice
- Intravenous Additives
- High Dependency Nursing
- Neo-Natal Cannulation
- Induction Course for Nursing Auxiliaries
- N.V.Q.- Underpinning Knowledge

In addition, the opportunity to receive merit for learning that occurs in the workplace, was availed of by 26 nurses who successfully completed work-based modules delivered by the Consortium. These modules, validated by the University of Ulster, are accredited at 20 CATS, Level 2, and can contribute to the attainment of the Diploma in Higher Education in Professional Development in Nursing (Work-Based Learning Pathway).

Once again, with specific reference to the Clinical and Social Care Governance agenda, it was pleasing to note that the following work-based modules attracted good support: -

- Introduction to Research
- Promoting Evidence Based Practice
- Anaesthetic Nursing
- Cancer Care Nursing
- Palliative Care Nursing

To be particularly welcomed is the demand this forthcoming year for the delivery of a work-based module focussing on Clinical and Social Care Governance.

Finally, our six-month post delivery evaluation reports for the period 1 April 2002 – 31 March 2003, have revealed positive comments from participants about the manner in which such programmes contribute to improving the quality of their practice.

4.2 Conferences

In September 2002 the Trust held a very successful conference entitled 'Evidence Informed Nursing'. The aim of the conference was to explore and highlight issues surrounding clinical practice and research especially the subject of critical analysis. It also provided an opportunity for staff to share examples of excellence in practice within Altnagelvin Hospitals H&SS Trust with their colleagues. The conference was attended by nursing staff throughout Ireland. The keynote address was by Mr Rob McSherry, Principal Lecturer in Practice Development University of Teeside.

Section 5.
USER INVOLVEMENT

User involvement in the planning and delivery of services is an integral part of Clinical and Social Care Governance. A Patient and Public Involvement Strategy is based on the following principles (Kennedy Report 2001)

- Transparency of decision-making processes and continuous two-way dialogue
- Clarity about where decisions can be influenced and involvement achieved, and give feedback on decisions that are made.

Effective user and community involvement is crucial to the delivery of high quality treatment and care. Clinical and Social Care Governance arrangements must involve users in ways that are meaningful, appropriate and acceptable to them. Involving users will provide a means whereby Altnagelvin Hospitals Trust can show that it is accountable to the population it serves. It can also help to improve staff/user communication.

The Trust has engaged in a productive partnership with a variety of User and Community groups in the past number of years. These include:

- Patients' Council
- Prostate Cancer Support Group
- Dermatology Users Committee
- Stroke Patients' Group
- Maternity Services Liaison Committee
- British Diabetic Association
- British Heart Foundation
- Chest, Heart and Stroke Association
- Derry Healthy Cities Project
- Healthy Living Centre, in Creggan
- Western Health and Social Services Council.

Section 6.
QUALITY – ACTION PLAN FOR 2003/04

INTRODUCTION

The success in addressing the quality agenda will be in the way in which we are able to make it a part of everyone's job and not have it as a separate initiative being managed by a specially formed committee. Recognising that achieving this goal requires ongoing monitoring and improvement strategies, the Action Plan for the year 2003/04 is as follows:

BASELINE ASSESSMENT

The foundation for an action plan was a Baseline Assessment of where the Trust and its employees are in relation to Clinical and Social Care Governance. The Clinical Governance Steering Group reviewed the systems in place within the Trust and made recommendations for improvement in "Delivering Quality – a Strategy for Clinical and Social Care Governance". A Baseline Assessment Questionnaire was sent to a random sample of senior staff, across all professional groupings, to assess their knowledge of and participation in Clinical Governance related activities. This has lead to the development of the following action plan:-

Action:

1. A quarterly Clinical Governance Newsletter will be published which will inform all staff of Altnagelvin Hospitals H&SS Trust's activities and plans.
2. A Web Page for Clinical and Social Care Governance will be made available on the Trust's Intranet site.
3. A series of lunchtime seminars will be organised to raise awareness amongst staff throughout the Trust.

QUALITY

The Hospital Quality Improvement Programme (HOSQIP) involves a range of initiatives designed to improve the Patient's experience of care. The strength of this programme is the involvement of the entire multidisciplinary team/s in development of good quality initiatives:-

Action:

1. Each Ward / Department will be required to develop at least one HOSQIP project to be implemented and audited in the year 2003/04.
2. Directorate Management Teams are required to provide lead ership and support to this activity through identification of a Directorate Facilitator to meet regularly with the Ward / Department Teams and receive reports on progress and assist with problem solving.

CLINICAL AUDIT

Clinical Audit is seen as an important vehicle for moving the quality agenda forward. It is already an established activity within the Trust, however, it is important to keep the momentum moving and to ensure that all clinical staff see audit as an integral part of their everyday work:-

Action:

1. Each speciality will be required to undertake a Clinical Audit of one of the professional guidelines issued by the Royal Colleges or other Professional / Standards Body. NB - It is not intended that this will replace all other audit activity within the specialty but this is one audit that will be expected to have been through the complete Audit cycle.

2. The changes in practice that have come about as a result of Audit Activity will be reported to the Clinical and Social Care Governance Committee by the Specialty.
3. Each Directorate will be required to submit their Audit Strategy to the Clinical Audit Committee.
4. During the year a list of prioritised Audits will be compiled on behalf of the Clinical and Social Care Governance Committee to be commissioned from the appropriate Directorate or, if applicable to more than one Directorate, commissioned from the Clinical Audit Staff.

CARE PATHWAYS

Care Pathways, developed from evidence-based standards, is another means of improving quality of care for patients:-

Action:

1. Each specialty will be required to develop at least one Integrated Care Pathway, subject it to the Audit cycle and report on outcomes.

ESTABLISHMENT OF RISK MANAGEMENT STRUCTURES

Ownership of the Risk Management Agenda by Directorates and Clinical Professionals within Specialties is critical to successful risk elimination and / or reduction. Within each Directorate lead clinicians have been identified for Risk Management:-

Action:

1. Each Directorate will establish its own Risk Management Committee, which will be supported by staff from the Risk Management Department. The remit of these committees

will be to review risks, incidents and complaints within their own department and pro-actively plan to reduce, control or eliminate them. NB - All incidents will still need to be reported to the Risk Management Department as well as to line managers as at present.

RISK ASSESSMENTS

A proactive programme of Risk Assessment which identifies actual or potential risks and puts in place action plans to reduce, control or eliminate risk, can contribute to improved quality of care:-

Action:

1. Each Ward / Department is required to carry out at least one Risk Assessment in the year 2003/04 and put in place an action plan and evaluate the effectiveness of this in reducing, controlling or eliminating the risk. They will be required to report on this to the Clinical and Social Care Governance Committee.

USER INVOLVEMENT

It is a requirement of the DHSSPS to involve users in the planning and delivery of services. Within Altnagelvin Hospitals H&SS Trust users are involved in a number of different ways e.g. the Patient's Council, Mothers Voice:-

Action:

1. The Clinical and Social Care Governance Committee has requested a review of this and the development of a coherent User Involvement Strategy.

EDUCATION AND TRAINING

Integral to delivery of high quality patient care is having staff who are knowledgeable, skilled and competent. This can only be achieved by a continuing professional development programme for staff within the Trust:-

Action:

1. Each Directorate will be required to produce a Directorate Training Plan, based on the outcome of the Staff Appraisal System.

REPORTING ARRANGEMENTS

It is important, particularly for the assurance of Trust Board, that there are robust systems for the reporting of clinical governance issues:-

Action:

1. Each Directorate is required to report, on a quarterly basis, the progress being made on the Action Plan.
2. The Reporting Template for Directorates will be reviewed and re-issued to ensure coherence and consistency.
3. Review of Directorates performance will take place at Performance Management Meetings.
4. A quarterly Report will be submitted to the Risk Management and Standards Committee; Clinical and Social Care Governance Committee and Trust Board which will incorporate the Directorate Reports.
5. An Annual Clinical and Social Care Governance Report will be published.

Section 7.
APPENDICES

The following is a list of the appendices:

1. Clinical and Social Care Governance Structure Diagram

2. Clinical and Social Care Governance Committee:
   - Membership
   - Terms of Reference

3. Risk Management and Standards Committee:
   - Membership
   - Terms of Reference

APPENDIX 1

Trust Board
Clinical & Social Care Governance Committee
Risk Management & Standards Committee
Assurance
Hospital Executive
HMT
Directorates
Accountability
Clinical audit
Health & safety
Infection control
Near patient testing
Drug & Therapeutics
Clinical Incidents
Clinical claims
Blood Transfusion
Local Medicine Governance

APPENDIX 2

MEMBERSHIP OF CLINICAL AND SOCIAL CARE GOVERNANCE COMMITTEE

Mr Denis Desmond, Chairman
Mr Neville Orr, Non-Executive Director
Ms Joan Casey, Non-Executive Director
Mr Gerard Guckian, Non-Executive Director
Dr Geoff Nesbitt, Medical Director
Miss Irene Duddy, Director of Nursing

In Attendance:

Mrs Therese Brown, Risk Management Director
Mrs Stella Burnside, Chief Executive

Administrative Support:

Mrs [redacted] Clinical Governance Co-ordinator

REMIT OF CLINICAL AND SOCIAL CARE GOVERNANCE COMMITTEE

1. To develop and review on behalf of the Trust a Clinical Governance Strategy.
2. To monitor the performance of the Trust against the Clinical Governance Strategy with particular emphasis on: -
   - 2.1 The management of major changes in policies and practices
   - 2.2 The instigation of appropriate changes that are made following investigation or audit
   - 2.3 The compliance of our services with National Service Frameworks and other significant clinical standards particularly those developing around Cancer Services.
3. To ensure that the Trust has appropriate internal control systems and that they are regularly reviewed. The frequency of: -
   - 3.1 Risk Management
   - 3.2 Clinical Audit
   - 3.3 Research and Effectiveness
   - 3.4 Staffing and Staff Management by benchmarking staffing, and skill mix and funded establishments within other District General Hospitals
   - 3.5 Education, Training and Continuing Personal and Professional Development
   - 3.6 The Use of Information about Patients' Experience, Outcome and Processes
   - 3.7 Consultation and Patient Involvement
4. To advise the Board on the resorting of Clinical Governance functions.
5. To ensure that Clinical Governance as an approach to quality improvement is understood by all members of the Trust.
6. To assist the Directorates in Developing a Clinical Governance Function alongside Risk Management Function within the Directorates.
7. To review on behalf of the Trust Board the result of internal audit reports regarding controls assurance standards and organisational control standards.
8. To produce an Annual Report.

APPENDIX 3

MEMBERSHIP OF RISK MANAGEMENT AND STANDARDS COMMITTEE

Dr Geoff Nesbitt, Medical Director
Miss Irene Duddy, Director of Nursing
Mrs Therese Brown, Risk Management Director
Mrs Paula Cunningham, Associate Director of Clinical Service Development
Mr Seamus Doherty, Allied Health Professionals Representative
Dr Raymond Fulton, Consultant Dermatologist
Dr Maurice O'Kane, Head of Research
Dr Michael Parker, Chair of Clinical Audit
Mrs Anne Witherow, Clinical Effectiveness Co-ordinator
Mr Richard Wray, Chair of Medical Staff
Mr Columb Henry, Non-Executive Director
Dr Gregg Furness, Chairman Blood Transfusion Committee

Administrative Support:

Mrs [redacted] Clinical Governance Co-ordinator

REMIT OF RISK MANAGEMENT AND STANDARDS COMMITTEE

1. To provide a systematic and strategic approach to the management of all risks within the Trust.
2. To promote the reporting of incidents or near misses in a culture of openness.
3. To monitor trends and risk management issues identified by the incident database.
4. Decide the nature and form of regular reports and advice to Executive Officers, and the Clinical and Social Care Governance Committee on urgent risk management issues and make recommendations as to solutions to avoid recurrences.
5. Advise on education and training relating to risk management and standards.
6. Establish and maintain a timetable for an ongoing programme of risk assessment throughout the Trust.
7. To receive and review reports from Risk Management and Standards Committee sub-groups.
8. To maintain the Trust's Risk Register and prioritise the Trust's risk portfolio.
9. To assure the Trust Board that controls assurance mechanisms are in place and are effective.
10. Clinical Policies, Guidelines, and Protocols will be submitted to the Risk Management and Standards Committee for approval. A central database of these will be kept within the Risk Management Department.
11. Clinicians (Medical and Non-Medical) wishing to undertake new Clinical Procedures will submit a written proposal to the Risk Management and Standards Committee for approval. Approval will be based on presentation of the evidence base for the procedure, the Clinician being properly trained to carry out the procedure and an examination of the potential risk and capital and revenue cost for the organisation.