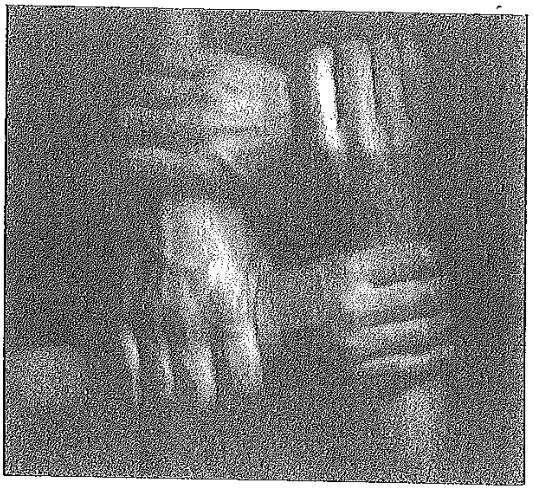
EHSSB

Implementing Clinical & Social Care Governance

ACUTE, COMMUNITY and PRIMARY CARE PERSPECTIVES



FEBRUARY

EDITED BY : DR TOM TRINICK AND DENISE TAYLOR
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forward

Clinical Governance has already been embraced throughout the other countries of the United Kingdom as a formal mechanism to raise the standards of clinical care. The Eastern Area Audit Committee organised this event to begin to explore ways in which Clinical and Social Care Governance could take shape in our Service in Northern Ireland. The high level of attendance at the meeting was in itself a statement to the enthusiasm with which Clinical and Social Care Governance is being grasped.

Many thanks are due to Dr Tom Trinick and his colleagues for the leadership and commitment which they have shown in organising the conference. Congratulations are due to Dr Trinick and Denise Taylor for editing this report on the conference proceedings. This report provides a wealth of material for those who wish not only to learn the meaning of Clinical and Social Care Governance, but to see how it might be put into practice.

Over the past 15 years there has been an increasing focus on quality within the Health and Social Services. Clinical Audit is well developed and is an integrated part of the activity in many of our Trusts and in Primary Care. We have seen the success of the multi-disciplinary approach to quality measurement and have began at last to invite patients and the public to give their views on quality. Whilst there has been progress, we have, however, lacked a systematic approach and there has been no sense that quality assurance is obligatory. Clinical and Social Care Governance builds on the work of the past and provides a management framework which will ensure continued improvement. This conference has thrown much light on how we might take it forward.

Dr Henrietta Campbell
Chief Medical Officer
Department of Health, Social Services & Public Safety.

The Eastern Health & Social Services Board has been pleased to support both the Clinical and Social Care Goverance Conference and the publication of these conference proceedings. Much was learnt and shared on the day and hopefully this document will be value in disseminating the experiences encountered so far.

Dr David Stewart
Director of Public Health.
Eastern Health & Social Services Board.

the eastern area audit committee

The Committee has representatives from Trusts, Audit Co-ordinators, General Practice and the Department of Public Health Medicine and Nursing at the Eastern Health and Social Services Board. Membership of the Committee is shown in Appendix 2.

The Editors

Dr Tom Trinick is Chairman of the Eastern Area Audit Committee. He is a Consultant Chemical Pathologist and Physician working at the Ulster Community and Hospitals Trust, Dundonald, Belfast.

Denise Taylor is the GP Audit Development Manager, GP Audit Team, Eastern Health and Social Services Board, Belfast.

Thanks

The editors would like to extend thanks to Maureen Toner, formally Clinical Audit Manager of The Royal Hospitals Trust, Anne McAfee, Clinical Audit Manager of Belfast City Hospital Trust and Edith Bezuidenhout of Eastern Health and Social Services Board for their active support in organising the meeting in February 2000.

Sincere thanks to the contributors from hospital, community and general practice who at the meeting so generously gave their time and expertise in excellent presentations, workshop facilitation and posters. The purpose of this publication is to share what was learned with a wider audience.

contents

introduction

I would like to express my deep gratitude to everyone who took part in the meeting. The aim of this meeting was to share ideas on how to implement clinical and social care governance and to explore problems that had been encountered during this early phase of implementation. Many people worked very hard to prepare for this meeting and in particular the chairmen, workshop co-ordinators and guest speakers made enormous and valuable contributions. Clinical and social care governance has now been taken up widely and with enthusiasm in Northern Ireland. The concept of governance allows everyone an opportunity to put quality first and this probably explains why it has been so readily accepted and taken up so quickly.

The wide diversity of approaches that came out in the meeting shows that quality can be achieved in a number of different ways. Interestingly certain common core issues kept coming up throughout the meeting. These included the need for proper resourcing of quality initiatives and the benefits of team working and good communication. But perhaps the hallmark of the meeting was the enormous enthusiasm for quality improvement and the exchanging of ideas that was very apparent.

On behalf of the Eastern Area Audit Committee I would like to thank everyone who took part and shared ideas so generously.

Dr TR Trinick,
Chairman, Eastern Area Audit Committee.

Professor Gary Love, Dr Philip McClements, Dr Ian Carson, Sir Donald Irvine, Dr Tom Trinick, Dr Jack McCluggage, Dr Don Keegan, Dr Henrietta Campbell.

keynote speakers

Sir Donald Irvine

President of the General Medical Council

We were very fortunate to have Sir Donald Irvine address the meeting. He stressed the urgent need for implementation of Clinical and Social Care Governance and described the increasing pressures on the medical profession to be more accountable to the public.

He outlined the journey the GMC had already made over the last decade, with the production of "Good Medical Practice", a blueprint of what patients could expect from doctors. He indicated that plans within the GMC for revalidation of doctors are at an advanced stage. Sir Donald commended the meeting organisers for bringing together Acute, Community and Primary Care perspectives on Governance and advocated the need for more such meetings. Although his time was limited, he heard several presentations from Eastern Board Trusts and commended the excellent work taking place.

clinical governance in primary care

Dr Azhar Farooqi,
East Leicester Medical Practice PCG & District Clinical Governance Lead

The official White Paper definition of clinical governance is now familiar to most health professionals, this states that:

"Clinical Governance is a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in care will flourish".

The essence of this definition is that clinical governance will ensure that there is "corporate accountability for clinical performance". For this to be meaningful there needs to be mechanisms in place to quality assure services provided to patients. These mechanisms will need to encompass the characteristics of a quality organisation i.e.:

- Quality improvement processes (e.g. audit) are in place
- Leadership skills developed at team level
- Evidence-based practice in use
- Innovations are disseminated systematically
- Clinical risk reduction programmes are in place
- Adverse events are detected and investigated
- Lessons are learnt from complaints
- Poor clinical performance is dealt with
- Professional development programmes reflect principles of governance
- Data to monitor care are of high quality.

This is an ambitious agenda for primary care, however the government's timescale is over a period of 10 years and we are not starting from scratch. General Practice for example has been involved in quality improvement for some time. Initiatives have included:

Vocational training. Inspection of training practices	1974
RCGP quality initiative	1983
New GP contract - target payments - PGEA	1990
MAAGs established to promote clinical audit	1991
GMC duties of a doctor	1995
Clinical Governance	1998

These initiatives have not been compulsory and have not been universally taken up by primary care. This is highlighted by a self reported survey from PCGs in Trent Region of England which showed that audit, peer review, appraisal and systematic professional development was absent in many practices.

clinical governance in primary care

One of the aims of clinical governance is to ensure equity in the quality of services so it is important that the "worst practices" are brought up to the level of the "best". In order to ensure this there needs to be a systematic and co-ordinated approach to achieving universal clinical governance which will have to include a monitoring and intervention mechanism where this is needed, whilst such a mechanism is likely to be devised on a national basis (revalidation, the work of CHI etc). The support mechanisms for clinical governance will need to be devised locally. In Leicestershire a systematic approach is being developed which involves action at district, PCG and PHCT level. Models are currently being developed and evaluated. Briefly these include;

District level

A mechanism to ensure that all potential providers of governance support (e.g. Universities, audit groups, Trusts, PCGs) develop a co-ordinated and systematic support to PHCTs. For example this may include joint training for clinical governance, a systematic approach to a priority such as CHD (i.e. linking audit, education/training and resource allocation).

PCG Level

Ensuring the resources are available (as a priority) to ensure PHCTs have the organisational support for clinical governance. Including access to quality improvement skills, effective team working and protected time.

PHCT Level

Ensure practices are trained in clinical governance and change management.

Resources

Time is given as a major barrier to the implementation of clinical governance and needs to be addressed by Primary Care Groups. The resource issues relate to both best uses of existing resources and of ensuring that clinical governance becomes part of core service specification.

One model may be to set practice or PHCT service level agreements that link resources to delivery on governance. An example of how this may look is as follows:

The practices agreed to:

1 Undertake quality improvement activity in at least two PCG identified priorities.
e.g. - CHD
- Diabetes
Develop disease register, undertake audit, set standards for achievement, service development. Meet standards.

2 Address at least two practice priorities one of which should relate to prescribing.
e.g. - Repeat prescribing
- Cervical cytology target

3 Hold monthly team "quality meetings", with agenda, attendance register and minutes with action points.

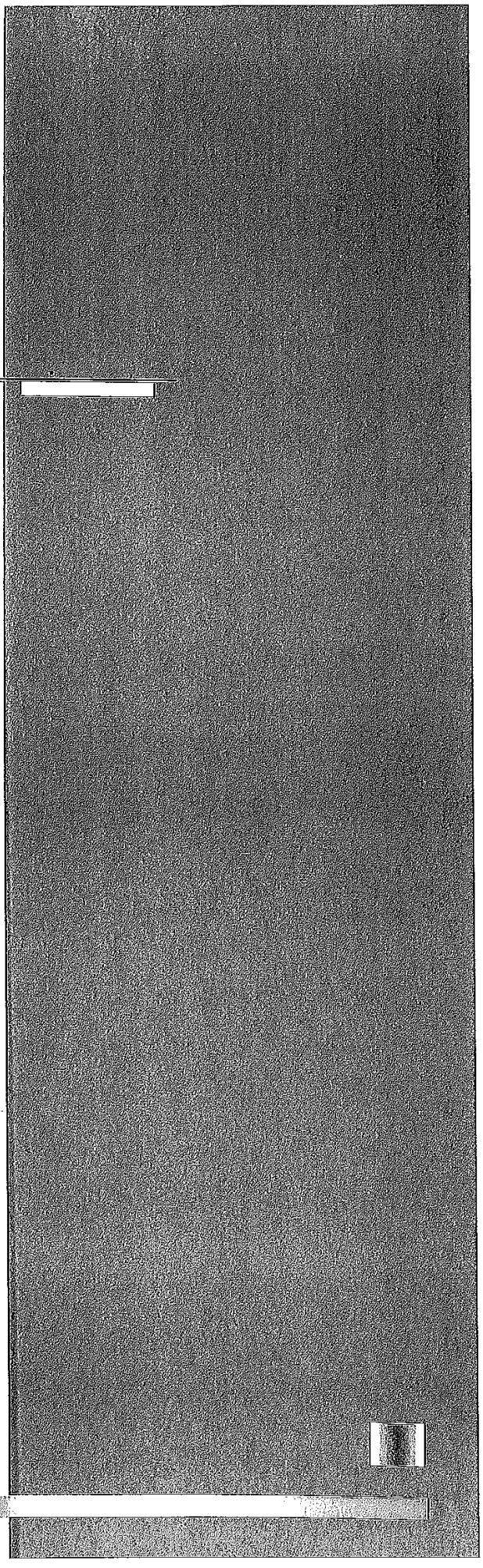
4 Initiate work toward the practice blueprint (1.3 year timetable for achievement).

5 Provide an annual clinical governance report for the PCG include audit data, anonymised complaints data and professional development information.

Resources Required :

Protected time, quality co-ordinator time, Project DiI/CHD Nurse, Practice PGEA, Pharmacy Advisor.

clinical and social care governance development in the eastern health and social services board area



Dr Ian Carson,
Medical Director

Clinical Governance:

- A concept which will ensure dependable local delivery of quality at the very "heart of the new NHS"
- This quality agenda is highly ambitious.

But is this what clinicians see?
Is this what they are focusing on?
Probably more likely to be -
"Clinical wot - Gov?"

There is uncertainty at present as to:

- Department of Health, Social Services & Public Safety (DHSS&PS) local arrangements?
- What does it mean for Trust Boards locally?
- How do we engage individual clinicians?
- Timetable? (HSC 1999/065), 16 March 1999.

Also:

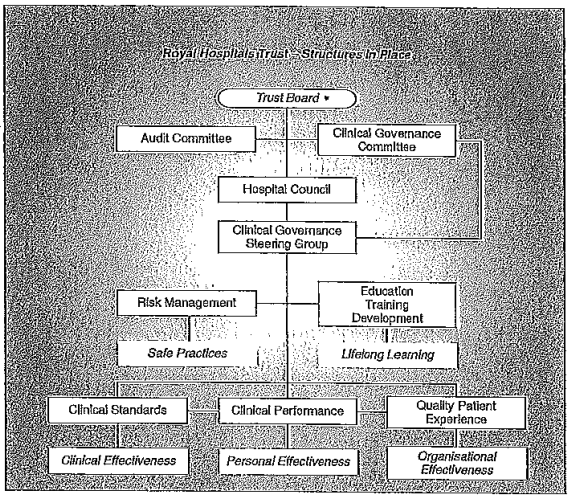
- "Relying solely on professional values does not seem to be an adequate or prudent means of predictably advancing the cause of quality" *- Leatherman and Sutherland - Evolving quality in the new NHS (Nuffield Trust 1998)*
- Uncertainty around different organisations involved in 'regulation' and performance measurement e.g. GMC, Colleges, Assessment Centres, Trust Employers.

Emergence of inevitable tensions:

- Non-threatening principles of TQM vs external assessment and accreditation
- Voluntary approach to quality improvement vs imposed mandatory standards
- Professional agreement on quality indicators vs public perception
- Encouragement & motivation of (hardpressed) staff vs necessary change of behaviour

Clinician's response ...

Paternalist	Ignore ... "in my day..."
Burnt out	Threat
Cynic	"Not another gimmick"
Autocrat	Interference
Antagonist	"What are you going to do about it?"
Pragmatist	Don't like it, but I'll make it work
Opportunist	'Leave for change



Steps are being taken towards Clinical Governance in the Trust:

1. Organisational stocktake
2. Action plan for implementation
3. Develop awareness
4. Develop reporting systems
5. Link to organisational development

What do we need?

- Teamwork, partnership, communication
- Attitudes that are appropriate
- Genuine commitment to quality that benefits patients
- Good information to assess the quality and performance of services
- Knowledge to support clinical decisions
- Time, support staff & other resources

Major reform is still needed, and the onus is on:

- The individual:
  - 'Duty of a Doctor'
  - Continuing Medical Education / Continuing Personal Development
- The professions:
  - Self regulation / revalidation
- The employer:
  - Clinical governance, CPD
- The government:
  - Needs to deliver!

Quality ...

Setting, delivering, monitoring standards A First Class Service - Quality in the NHS June 1998.

Targets for 1999/2000

HSC 1999/065 issued 16 March 1999:

- April 1999 - establish leadership, accountability and working arrangements
- Carry out a baseline assessment of capacity and capability, share with 'regional office'
- Develop an action plan in light of above
- Clarify reporting arrangements within Board and Annual Reports.

belfast city hospital trust

Dr Ken Fullerton,
Medical Director

Clinical Governance - what is it?

- Ensuring a high quality clinical service
- Demonstrating that this is the case

It is important to focus on the key issue, which is the delivery of a good and safe service to patients and clients. There is a danger that clinical governance may lead to a focus on structures and on bureaucracy rather than on quality. This does not mean that responsibility and accountability are not important, indeed they are crucial. At BCH we started with a simple statement and with a firm determination to remain focused on this.

Clinical Governance Domains

- Human Resources
- Estates
- Clinical

Clinical governance is not just about policing doctors. Providing a good quality service depends on the inter-relationship between clinical issues, personnel issues and estate (including health and safety). Many of the publicised clinical governance issues have at their core inter-personal problems, ill equipped staff and poorly maintained equipment. All of these dimensions must therefore be integrated within the Trust's clinical governance arrangements.

Important Components of Clinical Governance

- Professional Competence / development
- Risk Management
- Audit
- Quality
- Health and Safety
- Complaints

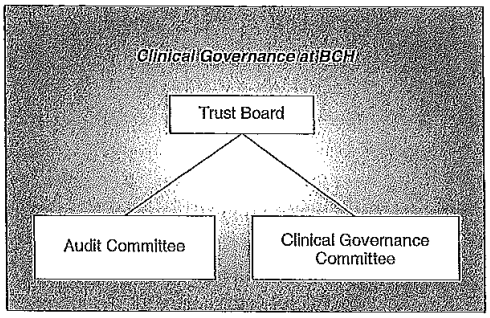
We are already doing many things well. The building blocks of clinical goverance are already in place. What is needed is the 'cement' to bring these various aspects together under a common and agreed purpose. Underpinning all is the important concept that all staff must be adequately equipped to deliver their particular responsibilities, and that a clear process exists both to establish competence and to facilitate development of appropriate skills.

Structures in BCH

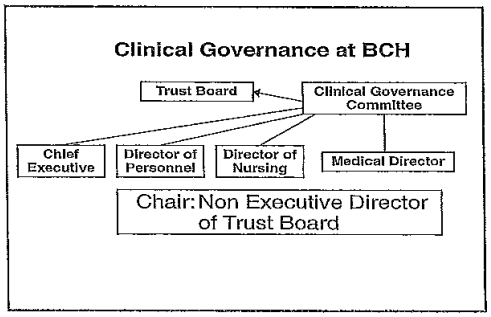
- Clinical Governance Committee
- Clinical Directorates
- Clinical Governance Support Group

Of the three structures which we have created to enable clinical governance, one, the Clinical Governance Committee is entirely new.

All Trusts have an audit committee, responsible to the Trust Board for issues of clinical audit.



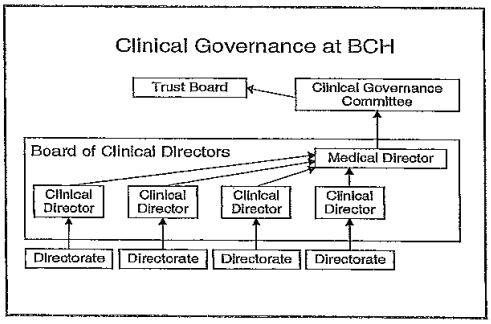
The Clinical Governance Committee serves the same purpose with respect to Clinical Governance. There will be areas of common interest with the Audit Committee.



The Clinical Governance Committee is chaired by a non-executive director, and has the above members at present. It is likely to evolve (and possibly expand) as roles and needs become clearer.

Clinical governance can only be delivered effectively at the clinical interface. A purely top-down approach will result in bureaucracy and form-filling, but not necessarily in service improvement. In this respect, clinical directorates and clinical teams are crucial. Without their ownership, clinical goverance will be at best ineffective.

The role of the clinical director is central, but this person is usually a full-time clinician, already pressurised by onerous management responsibilities. If they are to espouse clinical governance, then mechanisms to provide additional support to clinical directors need to be rapidly improved.



The Board of Clinical Directors is a pre-existing forum that has proved to be invaluable in allowing clinical governance issues to be discussed and explored. It allows for the generalisation of good practice between directorates, and keeps the medical director and the clinical directors informed.

Support Structures at BCH

Clinical Governance Support Group:

- Medical Director
- Clinical Services Director
- Quality
- Audit
- Estate Services
- Complaints
- Health and Safety

The lead staff in the important support areas have been brought together in Clinical Governance Support Group. They will henceforth produce a single, unified Clinical Governance report to replace the previous different reports produced by each lead. The twin functions of the group are:

- to provide support to the Clinical Governance Committee;
- to provide support to the Directorates and Clinical Teams in the development of clinical governance mechanisms, and in the delivery of clinical governance at the clinical interface.

Model of Clinical Governance in BCH Trust

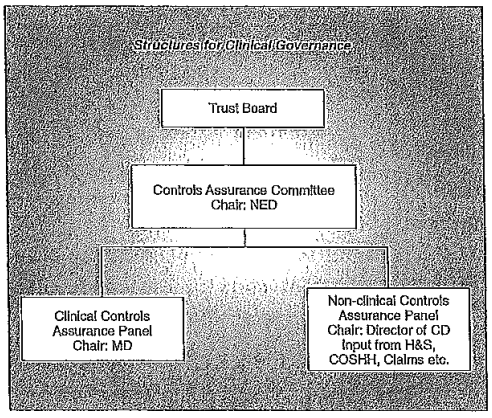
In carrying out a baseline clinical governance audit, we have found the EFQM Business Excellence model (http://www.niqc.com/excellence%20model.htm) to be a valuable tool.

This is our initial attempt to apply the model to clinical governance at a Trust wide level. It is also being piloted within a directorate and in some of the support areas.

mater hospital trust

Dr Jim McLoughlin,
Medical Director

In developing our structures for clinical governance, we have been very much aware of the definition of clinical governance: "A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish". This involves therefore not only setting up a framework which seeks to improve quality of care, but also creating a philosophy of outlook which reaches into all parts of the organisation seeking to do better. Initially we wondered if the term Clinical Governance was slightly threatening and the decision was taken to use the term 'Clinical Controls Assurance Panel', chaired by the Medical Director, working in conjunction with the non-clinical controls assurance panel, chaired by the Director of Corporate Development. Both of these controls assurance panels report to the Control Assurance Committee of the Trust Board, which is chaired by a non-executive director and has two other non-executive directors on the committee.



In reviewing our systems within the Trust, we felt it best to look at the elements of clinical governance which were already in place and then to build on them. The clinical controls assurance panel would therefore be an umbrella seeking to co-ordinate the activity of these various groups. Clearly other areas will need to be developed as time goes on.

1 Clinical Risk Management.
An active clinical risk management group is already in place that deals with untoward incidents and near misses.
Some major incidents, complaints and claims are fed into this group and also various set topics are dealt with, such as cardiac arrest management and the consent form.

2 The Postgraduate Tutor is a member of the group because of the importance we attach to postgraduate training as part of the idea of creating an environment of quality.

3 Various care pathways are in operation in the Trust, including one for obstructive airway disease and one for chest pain. Details of these have been submitted to the clinical controls assurance panel.

4 Medical Audit
Uni-professional Medical Audit and Nursing Audit in the Trust has produced many gains in the quality of care. The department has always had a healthy annual report and we feel it is important to encourage this.

5 Multi-professional audit is more cumber some, but certainly we do proceed with several audits per year.

6 Performance Procedures Mechanism.
We have had the unfortunate situation of having to deal with a poorly performing colleague. What is partly reassuring, however, is the fact that the individuals colleagues were willing to raise the concerns that they had with the Medical Director. The situation has been favourably resolved.

7 Other Groups
There are many committees in the hospital which have an impact on the quality of care that can be given. These include disaste planning, drug and therapeutics and resuscitation committees, control of infection etc. It is anticipated that we will seek reports from several of these, partially to emphasise the quality of work that is done, but also to help those participating in those groups to realise they are part of the complete clinical governance agenda.

8 It is envisaged that the controls assurance panel may ask some of the groups mentioned above to make changes. It is noted that the Director of Corporate Development sits on the Clinical Controls Assurance Panel, and this should hopefully facilitate change in this area.

As indicated above, several of the elements of clinical governance are working well. This may be helped by the fact that the Trust is a compact one and many of the input areas are the remit of the Medical Director, namely Clinical Risk Management, Claims Management, Major Complaints Investigation, Performance Procedures and Multi-professional Audit. This allow various issues to be cross referenced within the groups.

As regards the size of our controls assurance panel, we have still to decide on the optimum size. There is a difficulty because a smaller committee gives greater efficiency, but on the other hand it is important to extend the ideas of quality improvement to all areas of the Hospital. We have therefore used the opportunity to have one individual serving more than one function. For example the postgraduate tutor is an anaesthetist, the medical co-ordinator is an obstetrician, the chairman of the Medical Staff Committee is a radiologist. Many areas therefore will be represented by the relevant clinical director.

A further area which we have found of considerable success is to use other contacts to promote awareness of the quality agenda. For example, the Medical Audit department's meetings have been used to promote issues raised by claims, complaints, etc. In addition, job plan interviews with consultants are used too as an opportunity to discuss continuing medical education and competence of colleagues. It may be that in the future this will become a full appraisal.

We are just beginning on the clinical quality agenda, and much work will need to be done over the coming years. There are various areas that we need to develop, including training within the Trust and a research and development strategy. We need to improve the mechanisms by which complaints management reaches the quality agenda. There is also some difficulty in deciding what is clinical and what is non-clinical as they are clearly different ends of the same spectrum. Some cross referencing between groups will be of help. The cross membership and the fact that we have an over-arching controls assurance committee will hopefully help this.

Eleanor Hayes
Director of Patient Services

The development of clinical and social care governance in the National Health Service is a major component of the changes being introduced by the present government to ensure there is fair access to consistently high quality healthcare for all patients. The government's proposals for action were set out in the White Paper. "The New NHS", and in the consultation paper "A First Class Service: Quality in the new NHS" in the summer of 1998.

At this time, there was no guidance from DHSS & PS, however, Green Park Healthcare Trust produced a consultation document in January 1999 which was circulated to staff including Clinical Directors, Head of Departments, Lead Clinicians.

Consultation Document

The document described the main elements of clinical and social care governance, and overview of the current activities and effectiveness of existing systems which would contribute to clinical governance. In particular, staff were asked to comment on risk management, clinical involvement, life long learning and the culture of the organisation.

The views of the staff were collated and action plans produced to address current systems and how these could be integrated to support the clinical governance agenda.

Risk Management

One of the most important aspects of clinical and social care governance is the demonstration of a control assurance concept, based on best governance practice.

Fundamental to the success of the process is the effective involvement of people and functions within an organisation through the application of self assessment techniques to ensure objectives are met and risks are properly controlled. The common thread linking clinical governance and wider controls assurance is risk management.

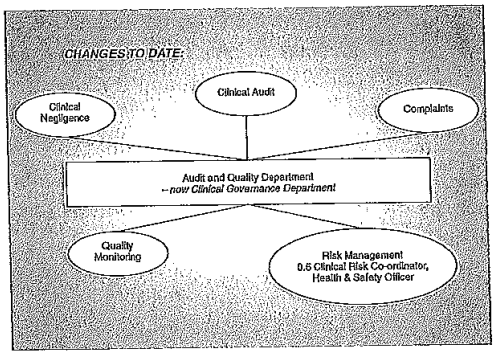
To ensure that the Trust was in a position to address all risks within the organisation, the following action plan was agreed:

- conduct a baseline assessment of current risk management processes;
- use Clinical Negligence Scheme for Trusts (CNST) standards as a bench mark to work towards;
- appoint 0.5 wte Clinical Risk Co-ordinator;
- integrate clinical and non-clinical risk management.

Draft Strategy for Clinical and Social Care Governance

The draft strategy which contained action plans to address the main areas within clinical governance i.e. risk management, training and development user involvement, quality and audit etc., was presented to the Chief Executive, Directors, Clinical Directors and Lead Clinicians. Their comments were addressed and the final document produced.

To raise awareness of clinical governance and the Trust's strategy, a number of workshops were held for all groups of staff within the Trust (nurses, PAMS, administrative staff).



A number of important organisational changes have taken place within the Trust for example, the Audit and Quality Department has been reorganised and is now the Clinical Governance Department. This department will be responsible for assisting the lead clinicians drive forward and co-ordinate the clinical governance agenda.

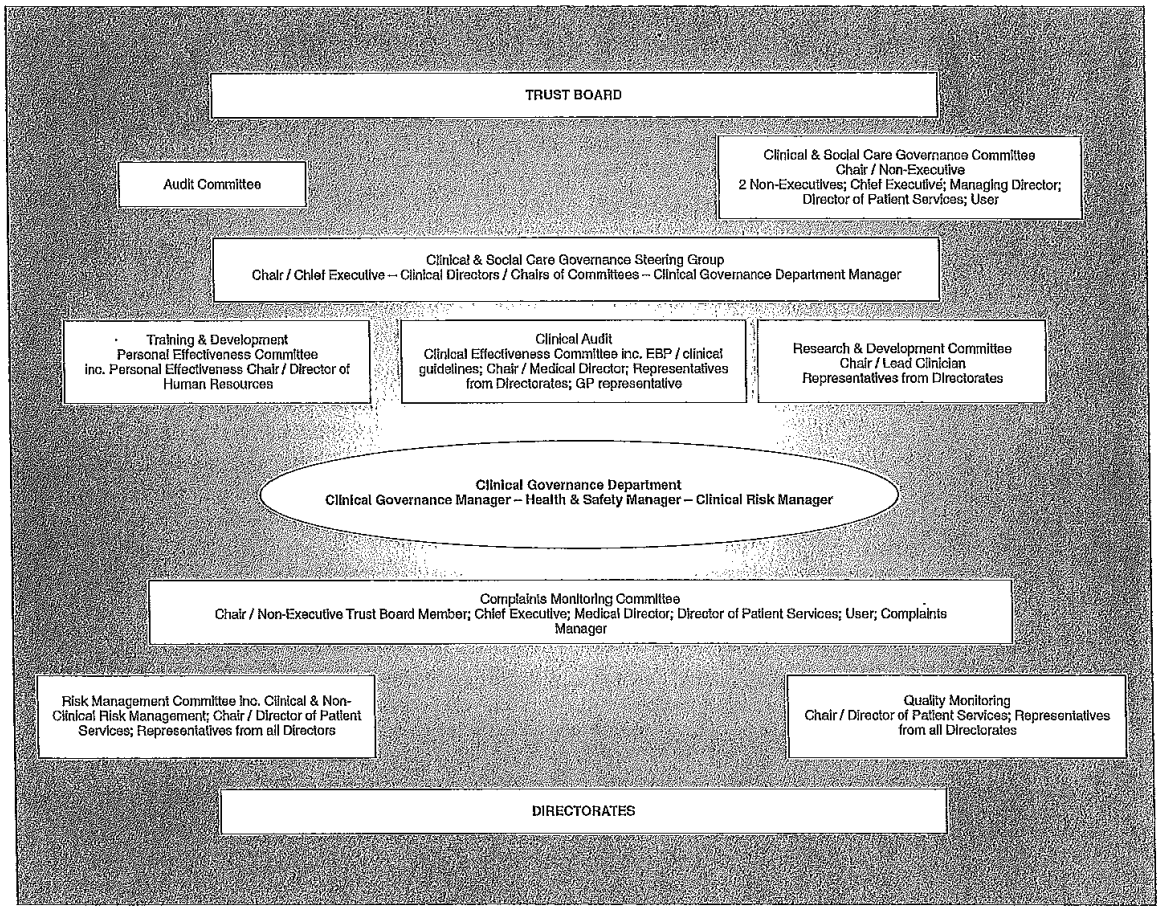
Conclusion

A new organisational structure and communication network has been introduced to support clinical governance (see diagram on page 21) and workshops are being held on a regular basis to inform and update staff on clinical governance issues.

The clinical governance agenda within the Trust is still at an early stage, however, we have been encouraged by the support and interest of all groups of staff.

We believe the consultation period and documentation that was widely distributed assisted us in this process and encouraged staff to contribute their views and concerns on the way forward.

Green Park Healthcare Trust - Structures in place



ulster community & hospitals trust

Dr Tom Trinick,
Clinical Governance Lead

The Ulster Community and Hospitals Trust is unique in covering an acute general hospital and associated community services within one management structure. In recognition of this unique structure, clinical and social care governance is being developed using an acute clinical governance committee and a separate community clinical governance committee. These structures are co-ordinated through a steering committee and a Trust Board based review committee. It seems likely that the acute and community committees will come together in time, but will continue to work through the Clinical Directorate system on the acute side and the Programme Heads on the community side. Committee aims and functions have been developed along with a development programme. A Trust policy is being developed, awaiting guidelines from the Department of Health Social Services & Public Safety.

The three key elements remain:

- protecting patients / clients
- developing people
- developing teams and systems

A no-blame culture has been endorsed throughout the Trust with the emphasis on learning from mistakes and complaints. Clinical governance is an agenda item at every directorate meeting in the hospital and every programme of care meeting in the community. A major difficulty for establishing clinical governance is to make sure that there is good communication throughout the Trust. One approach being adopted in the Ulster Trust involves the Pathfinder electronic information programme.

Pathfinder is a national consortium of interested Trusts who have developed an electronic answer to sharing information, distributing guidelines and establishing evidence based practice via computers. In time it can allow clinical notes to be stored electronically with easy look-up facilities. Pathfinder is being rolled out across the Ulster Trust and will allow the introduction of evidence based medicine together with pathways of care. Care pathways are being developed across the GP-Hospital interface.

Multiprofessional audit is well developed and remains the 'executive arm' of clinical governance. Work is well advanced on a Trust wide risk management programme which is to be piloted using a single report form with information held on a central computer for collation and analysis.

The main building blocks of clinical governance remain:

- risk management
- audit and complaints
- professional performance
- continuous professional development
- research and development
- evidence-based medicine
- user consultation.

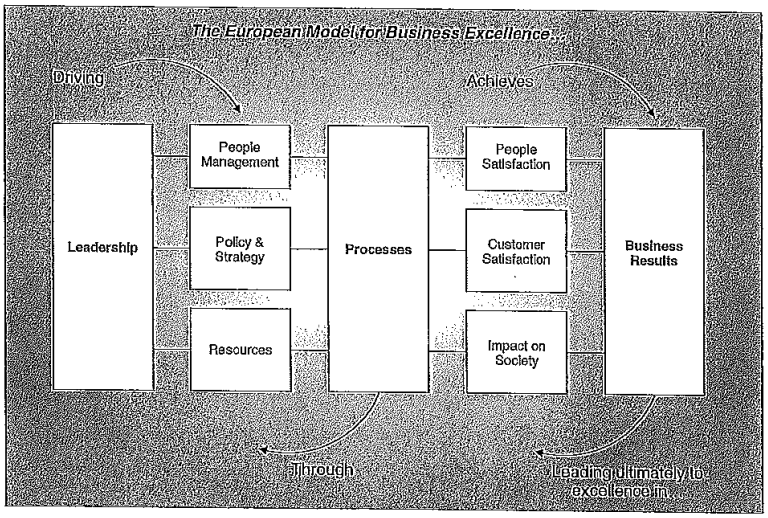
Continuous professional development is being introduced for all staff. Appraisal is being introduced for consultant staff and 'behaviourally anchored rating scales' (BARS) are being used for other staff groups.

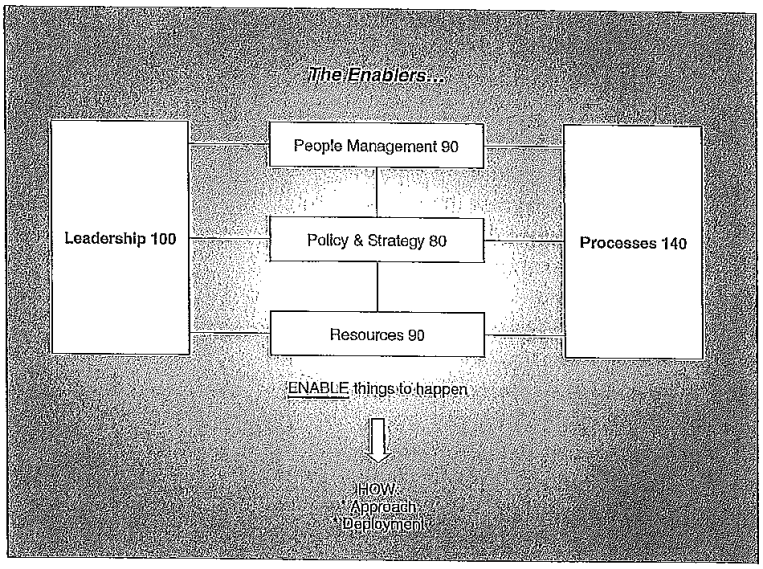
Good communication is essential in order to change the culture towards improving quality. A series of meetings and seminars are on-going in the hospital and the community to keep all staff fully informed. The benefits of this culture change are already becoming apparent.

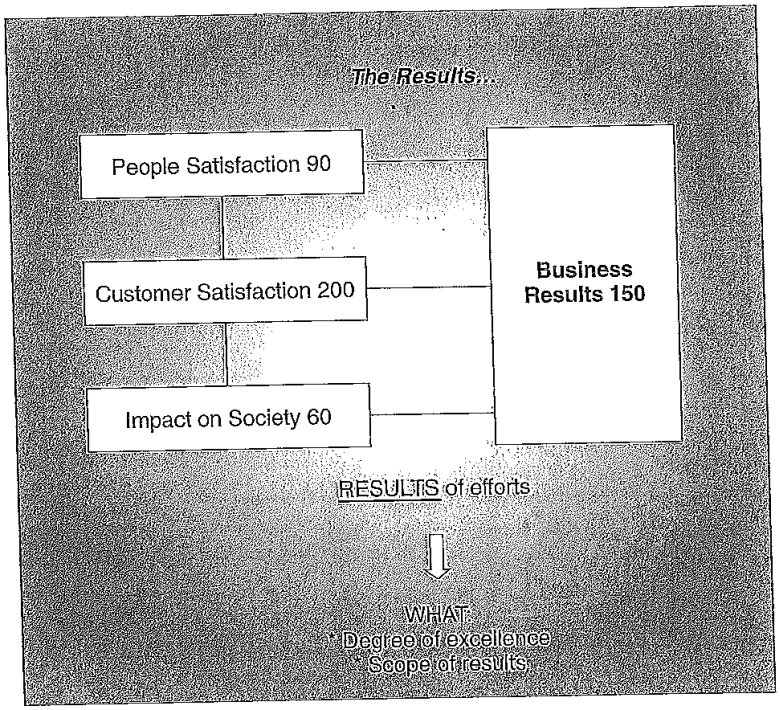
down lisburn health & social services trust

Alan Finn,
Director of Mental Health and Nursing

The Trust has adopted the European Model for Business Excellence.





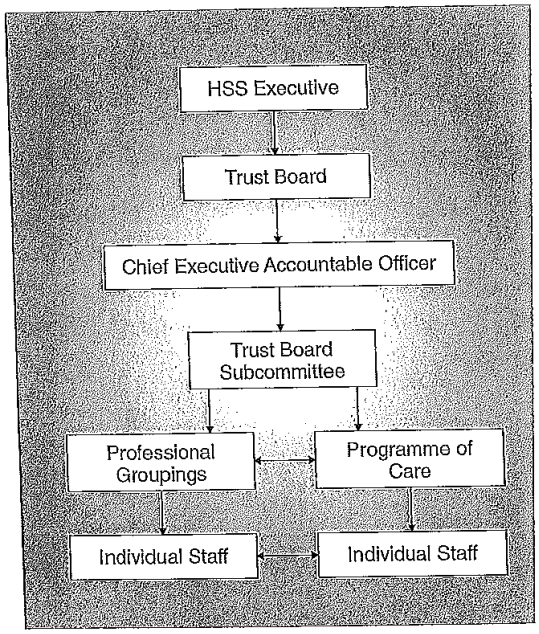


How we started:

A Senior clinician identified the need for the Trust to further explore clinical and social care governance. This resulted in:

- Conference attendance
- Further reading
- Networking
- Clinical and social care governance steering group then developed ideas
- Training and awareness sessions
- Self assessment
- Appointment of quality support team member
- A Trust Board Subcommittee was then formed (see diagram)
- Workshop was held to plan strategy - December 99
- Now currently awaiting local guidance

What does the Trust Board Subcommittee look like?



What is its role?

- Ensure clinical performance improves
- Identify quality problems and understand causes
- Identify methods of improvement
- Provide regular reports to Trust Board
- Produce an annual report

What did our self-assessment say?

General themes:

- strategy development, clinical and social care
- governance, audit, research, risk management
- development and implementation of systems
- improved communication
- staff appraisal
- research and development
- audit, evidence-based practice
- training associated with all of above
- time for staff to take forward issues
- information (access to, dissemination of)
- better use made of complaints and critical incidents
- involvement of users, commissioners developed

What activities are we currently involved in?

- Training and awareness: 'roadshow' planned for 2000
- Risks being identified / assessed and shared
- Example: -untoward incidents/ litigation (HRRI)
  -IIP development
  -CPD
  -Induction formalised
  -Mandatory training specified
  -Training needs identified
  -Target areas identified
- Research / joint appointments - co-ordination needed
- Investment needed. Database application
- Clinical audit activities, co-ordination and investment needed
- Development of shared governance model & strategy paper
- Health and Safety, Trust and Directorate approach being co-ordinated
- Information needs, PCIS, business case being developed
- ISO's 9000/1401, Charter Marks 13A and 6 applied for
- King's fund (HQS) accreditation in Mental Health
- Acute services commencing, EFQM application Sept 2000
- Subgroup meetings scheduled
- Early briefings to Trust board
- Annual report due April 2000
- Local strategy for clinical and social care governance, arrangements to be developed March 2000
- Policy/guidance on dealing with incompetent practitioners needs further development

Key issues to consider

- Clinical Audit
- Risk Management
- Clinical Effectiveness
- Evidence-based Practice
- Complaints
- Multidisiplinary working

Need to examine current activity, strengths and weaknesses

Questions to be answered:

- How do we integrate clinical quality processes into QMP?
- Do clinical leaders need skills development?
- What is the current application of evidence-based practice?
- How is good practice disseminated?
- How are lessons learnt/ shared (adverse incidents/complaints)?
- What current data is collected to be monitored in clinical care?
- How do we ensure professional development programmes applied to all clinical professionals?

Emerging issues:

- Watershed in relationships - professionals / organisation's clinical problems just don't belong to a professional, but to the Trust and Board

First step on the road away from clinical freedom to managed and corporately controlled forms of practice.

- Challenge to have all clinical professions involved
- Strong leadership and support particularly required from Medical and Clinical Directors.

S & E belfast health & social services trust

John Donaghy,
Research and Clinical Governance Project Manager

Why Clinical and Social Care Governance?

Origins of Clinical Governance

Clinical Governance is a way of addressing concerns about the quality, responsibility and accountability of health care. Some changes in health care organisations have been prompted by issues of such seriousness that they have resulted in major enquiries. Variations and standards of care between different services have been well documented.

Under the previous government and the market driven system for the NHS, many felt that the quality of professional care had become subservient to price and quantity on a competitive ethos. Moreover some serious clinical failures, for example, in breast and cervical cancers screening programmes, had been widely publicised and helped to make clinical quality a public confidence issue.

The development of Clinical Governance is designed to consolidate and universalise often fragmented and far from clear policies, organisational structures and approaches, to create organisations in which the final accountability for Clinical Governance rests with the Chief Executive of the health organisation - with regular reports to Board meetings (equally as important as monthly financial reports).

Direction is required from Government to facilitate inter-organisational accountability. However, each organisation has to work out accountability arrangements in detail and ensure that they are communicated throughout the organisation.

Linking Clinical and Corporate Governance

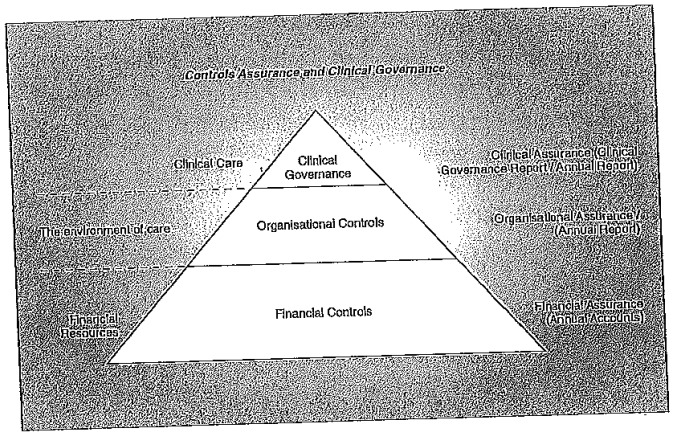
Clinical Governance needs to be seen in the context of existing work to promote effective Corporate Governance. It is entirely consistent with and complementary to the development of controls assurance.

The diagram on p28 illustrates how controls assurance work can be seen as an essential underpinning to the delivery of high quality clinical care.

Controls assurance is described by Colin Reeves, Director of Finance and Performance at the NHS Executive, as "the final piece of the corporate governance jigsaw". It is a process designed to provide evidence that NHS organisations are doing their "reasonable best" to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders against risks of all kinds.

Fundamental to the process is the effective involvement of people and functions within the organisation through the application of self assessment techniques to ensure objectives are met and risks are properly controlled.

In basic terms, the task of delivering quality care to patients is made easier if organisations have in place sound financial systems and complementary arrangements for assessing and managing risks - for example, those which impact on the health and safety of staff and patients. Procedures for clinical waste disposal and infection control are good examples which can have a very direct impact on the outcomes of patient care.



What is Clinical and Social Care Governance?

Definition of Clinical Governance

"Clinical Governance can be defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence and clinical care will flourish". (A First Class Service : Quality in the New NHS)

Definition of Clinical and Social Care Governance

"Clinical and Social Care Governance is a framework through which health and social services organisations are accountable for:-

- Continuously improving the quality of services
- Safeguarding high standards of care and treatment by creating an environment in which excellence flourishes"

(Brian Grzymek, Director of Performance Review and Secondary Care, DHSS &PS).

Clinical and Social Care Governance addresses and secures improvements in the quality of care delivered by health and social services. The Clinical and Social Care Governance Framework builds on anc strengthens current procedures for risk management, clinica audit, quality, clinica effectiveness, evidence-base practice, research an education, continuing professiona learning and developmen professional self-regulatio complaints management an the learning of lessons fro poor performance.

Clinical and Social Ca Governance brings all of the components togeth promoting a co-ordinat approach to the provision quality care, while ensuring greater focus on t standard of clinical and soc care practice.

The integration of Health a Social Services in North Ireland means t Governance arrangeme must include social care addition to clinical care.

A Clinical and Social Care Governance Framework does not replace the current arrangements for the discharge of statutory functions. Instead it strengthens and builds on current statutory functions arrangements.

The Quality Framework

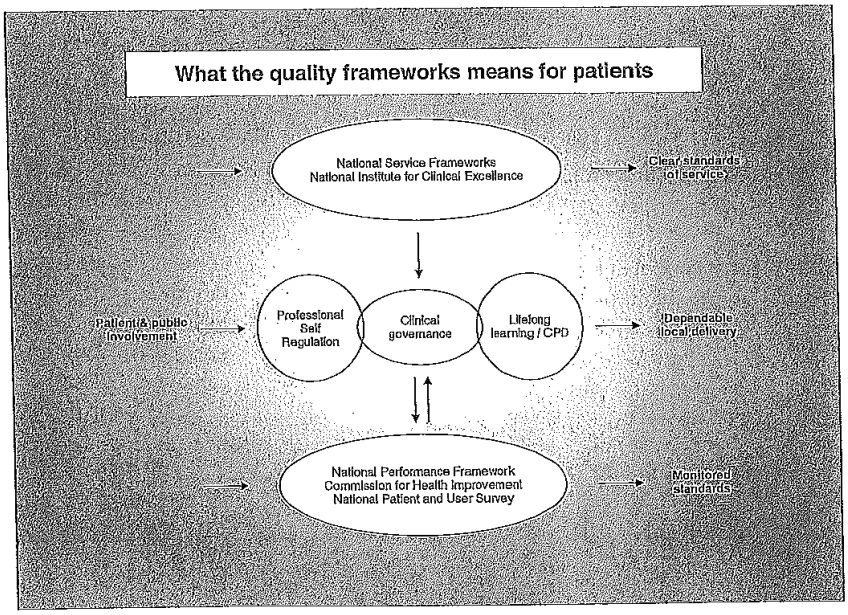
There are three main elements to the strategy for improving quality in the NHS:-

- Setting clear national quality standards, through National Services Frameworks and the National Institute for Clinical Excellence.
- Mechanisms for ensuring local delivery, of high quality clinical services through clinical governance reinforced by a new statutory duty of quality and supported by programmes of life long learning and local professional and self regulation.
- Effectiveness systems for monitoring delivery of quality standards, in the form of a new statutory Commission for Health Improvement and a NHS performance assessment framework together with a first national survey of patient and user experience.

Setting and Monitoring Standards

New terms within the Quality Framework are offered below:-

- The National Institute for Clinical Excellence (NICE) will produce and disseminate around 30 to 40 clinical guidelines a year, with associated clinical audit methodologies.
- National Service Frameworks will set national standards and define models for a specific service or care group.



- The Commission for Health Improvement will provide national leadership to develop and disseminate the principles of Clinical Governance. It will independently scrutinise local arrangements through a series of local reviews. It is anticipated that Trusts will be visited every three to four years. The Commission will also have a role in tackling serious or persistent clinical problems.

- The National Performance Framework will be a monitoring tool in the six areas of: health improvement, fair access, effective delivery of appropriate health care, efficiency, patient and carer experiences and health outcomes.

- The National Survey of Patient Experiences will be a systematic survey on specific topics.

How to address Clinical and Social Care Governance?

The European Business Excellence Model

Some Trusts in Great Britain and Northern Ireland are using the European Business Excellence Model as a tool for self-assessment in clinical governance.

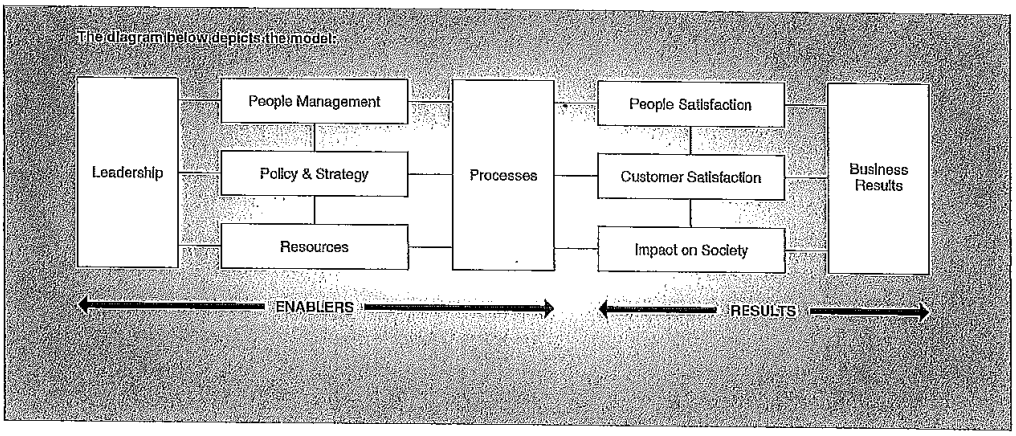
The model consists of nine elements, which are grouped into two broad areas: -

- Enablers - how we do things
- Results - what we target, measure and achieve

Each of these nine elements is an area of activity within an organisation, which contributes to the organisation's success. By regularly reviewing activities and results in these areas, organisations can test their progress towards business excellence. The nine elements are: -

1. Leadership - how the behaviour and actions of senior managers and other leaders inspire, support and promote continuous organisation improvement.
2. People Management - how the organisation releases the full potential of its people.
3. Policy and Strategy - how the organisation develops, deploys and reviews policy and strategy and turns it into plans and actions.
4. Resources - how the organisation manages resources effectively and efficiently.
5. Processes - how the organisation identifies, manages, reviews and improves its processes.
6. People Satisfaction - the level of people satisfaction that the organisation is achieving.
7. Customer Satisfaction - the level of customer satisfaction that the organisation is achieving.
8. Impact on Society - what the organisation is achieving in relation to the needs and expectations of the community at large.
9. Business Results - what the organisation is achieving in relation to its planned objectives, needs and expectations.

The diagram below depicts the model:



Key Issues

Strategy:

- Incorporate culture and values
- Paint a picture
- Start with major risk areas
- Integrate corporate, clinical and social, a and individual governance
- Control driven
- Integration and facilitation

Implementation:

- Model to include other quality processes
- Build on statutory functions
- Prepare managers for clinical and social care governance
- Support managers

Other factors:

- Staff employed by other Trusts
- Discharges to other Trusts
- Prescribing drugs
- "whistle blowers"
- Resource issues

New Initiatives in the Trust

- Learning and Development Strategy
- Person Centered Information Systems (PCIS)

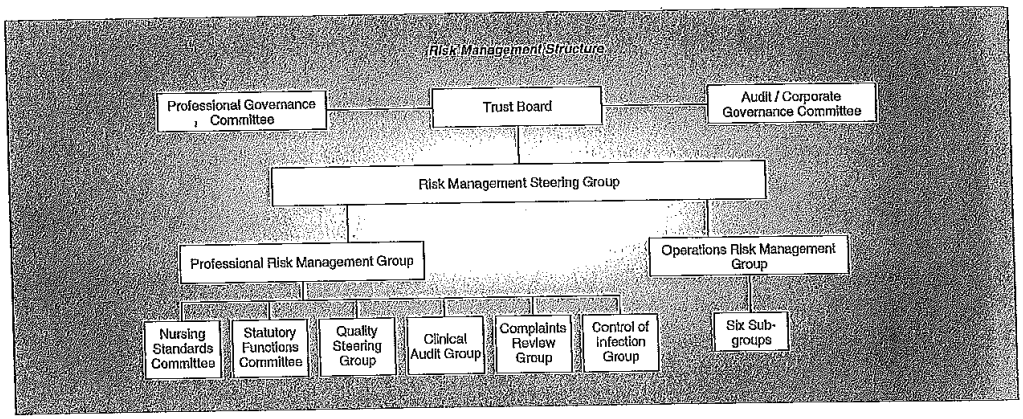
N & W belfast health & social services trust

Brenda Connolly,
Director of Nursing

Clinical and Social Care Governance - 3 areas are being addressed:

- Risk management strategy
- Quality strategy
- User involvement

Risk Management Strategy



Professions Risk Management:

- Monitor the implementation of the Risk Management Strategy in all its clinical and care aspects, across the boundaries of hospital, community / primary care and social work services
- Lead and maintain the cultural change, which is needed to reduce clinical / care risk in the Trust
- Maintain a continual awareness of the clinical / risk problems within the Trust
- Ensure that regular service reviews of risk factors are undertaken
- Design a program to demonstrate improvement in the clinical / care risk management effort.

Quality Strategy

Project Board	Six directors
Project team	Representatives from all service / programme areas
Subgroups	Multiprofessional audit Charter group Consumer care Consumer surveys / research MAH Quality Group

User Involvement:

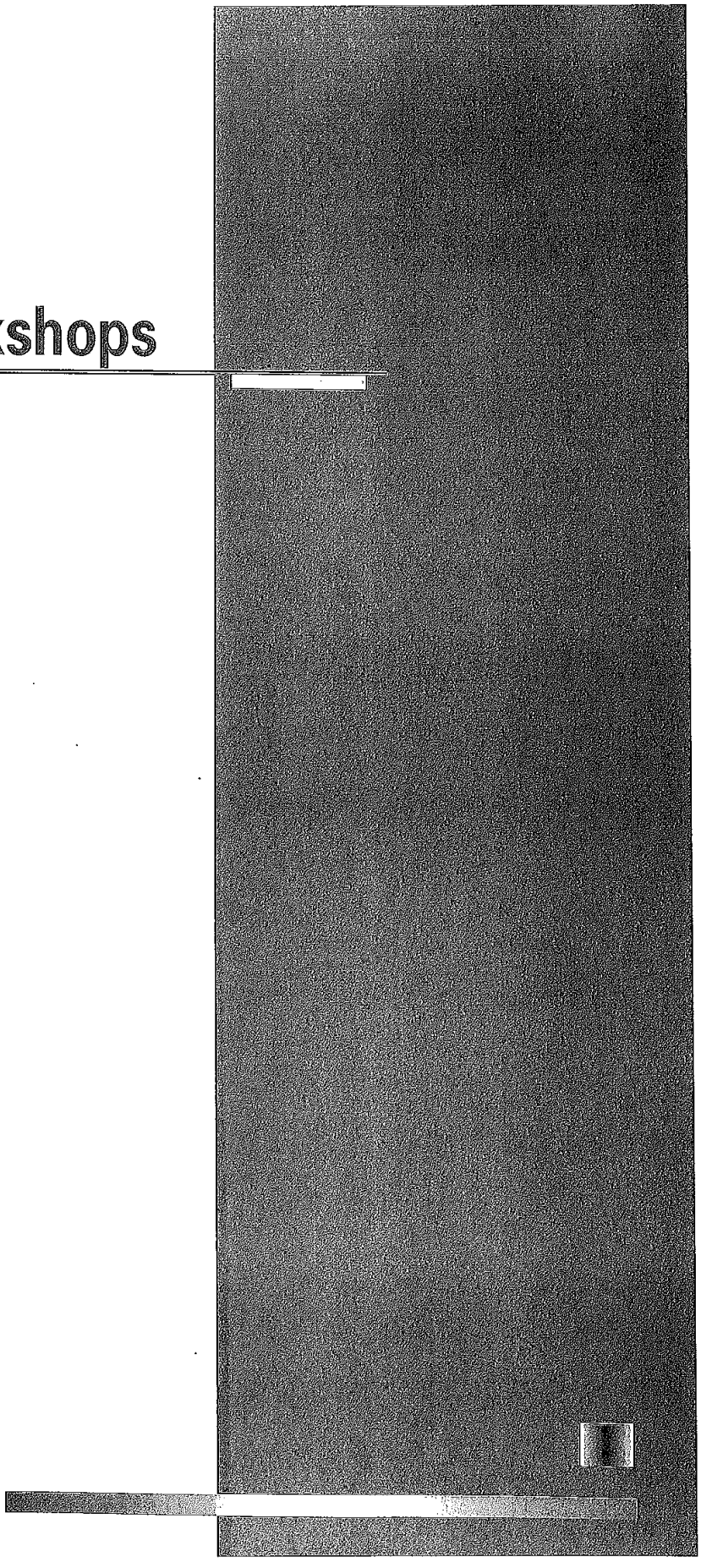
Work has taken place with:

- Focus Groups
- Health Action Zone
- Users / carers groups

Issues yet to be addressed:

- Integrated Health & Social Care organization
- Staff ownership
- Staff support and development
- Information technology
- User involvement

the workshops



workshop 1

Management of clinical risk in the context of Clinical Governance

Facilitator: **Mr. Ray Hannon**
Belfast City Hospital Trust

This group was tasked with exploring two important "quality control areas" are as within the framework of clinical governance.

These were

- The concept of **risk management.**
- Within the umbrella of risk management, **adverse event reporting**

The concept of risk management is relatively new in UK healthcare though well established in USA. **Definitions** that are easily understood should be used to introduce all staff to the idea:

- **Adverse (clinical) event**
  a situation or circumstances where injury, or physical/psychological harm have actually occurred.
- **Near miss**
  a situation or circumstances where injury, or physical/psychological harm was narrowly avoided.

Different groups might have slightly different definitions so it is important that everyone is aware which definitions are in use for all the aspects of risk management. Official definitions will be introduced by DHSS soon.

- **Risk**
  a situation or circumstances where loss, injury, or physical/psychological harm are possible.

- **Run a risk**
  to be in, or get into, a risky situation.

- **Risk analysis**
  a systematic and methodical investigation process undertaken to assess the clinical, physical and financial risks affecting healthcare.

Our role in healthcare should be to improve the quality of patient's treatment; that automatically implies minimising risk to the patient and the NHS Trust.

- **Minimise**
  to reduce (loss or damage) to the smallest possible amount or to make as insignificant as possible. Minimising risk will not come about by accident and the process has to be managed.
- **Manage**
  to control or administer affairs or events.

There was general recognition that by definition minimisation of risk could consume a disproportionate amount of resources and in real life risk can only be reduced to acceptable levels. However there is no clear answer as to who decides the acceptable level. NICE? The professional bodies? The purchasers? The Trusts? Clinical teams? An individual practitioner? It is hoped that in time all major aspects of healthcare will be covered by evidence based guidelines that should in theory allow models of best practice to be developed at local level. Recent failings of healthcare would suggest that it could be inherently very risky to allow individuals or indeed small teams decide acceptable levels of risk for care. It would seem inevitable that external agencies or larger groups will help decide standards of care and hence the acceptable level of risk.

The principle of risk management in healthcare should be to improve the quality of healthcare for all patients and not rely on legal defence of negligence claims or complaints.

The aims of a clinical risk management programme could be summarised as

- Reduction and "as far as possible" elimination of harm to patients.
- Recognition that things can and do go wrong.
- To continue to treat the patient appropriately.

There should be continuity of care and the patient should not be further disadvantaged because of e.g. injury and subsequent complaint.

- The injured patient needs to be adequately compensated
- The "assets" of the Trust and health service need to be protected in the long term. These assets are not all financial and loss could include:
  -Loss of reputation of the Trust and health service
  -Loss of staff morale
- Any clinical risk management programme should be striving to improve quality of health care, not merely being a damage control exercise after the event. We must learn from adverse events and prevent them recurring (audit). We should also be proactive in anticipating, analysing and preventing risk. This would fall under the general governance principle of learning and implementing change for the better based on analysis of previous experience.

Extent of the problem

- 8 million hospital admissions per year
- 320,000 adverse events (4.0%)
- 45,000 claims of negligence (0.6%)
- 40,000 deaths (0.5%)
- 20,000 permanent disability (0.25%)
- 22,000 paid claims (0.2%)
- Financial cost of negligence claims = £200 million per year.

However it can be seen that many more patients suffer adverse events than have successful claims and these often go unrecognised or are resolved without recourse to litigation. There are hidden costs in adverse events e.g. increased length of stay, complex care packages as a result of poor care or complications etc.

Implementing risk management:

The group had strong opinions on this area.

- Leadership and responsibility.
  Risk management won't take place automatically. It has to be embraced by leaders within the organisation. It will not be implemented properly if a heavy handed or solely top down approach is adopted.

- Developing a risk management team or committee (RMC).
  It is not sufficient for risk management to be implemented by individuals or small isolated groups. For it to work there must be time, personnel and adequate resources. Central to this is a risk management committee to guide the process.

- Cost
  it was argued by most people that effective risk management would eventually reduce the cost of health care but it is difficult to introduce new long-term initiatives without new resources if present staff feel overwhelmed by their day-to-day roles.
- There will be long-term practical issues of implementation.
  Rome wasn't built in a day and systematic risk management will take time and continuing effort
- All will require cultural changes.
  Staff must be prepared to be open and honest about their performance. The concept of a "no blame" culture has to be embraced for investigation of adverse events to be real. It is not the role of the RMC to apportion "blame".

  Their role is to protect patients and minimise loss. Other parts of the trusts management structure or indeed professional bodies can attempt to apportion blame at a later date.

  Continuing care of injured patient. If a patient is injured or harmed, arrangements should be made so that their proper care continues and that they do not suffer further injury.

- Continuing to treat with same team or arrange alternative care
- Explanation of what happened
- Explanation of why it happened
- Remedial action - learn from the event and tell the patient what measures have been put in place
- Compensation

Support of staff involved in litigation, complaints or major adverse events

- Talking through with senior colleague.
- Senior personnel have probably been through similar problems and should be prepared to be a "shoulder to cry on".
- Talking through with someone else who has been in similar position
- Supportive inquiry process i.e. trying to avoid "blame"
- Readily available legal advice

One of the central areas that the group discussed was the of adverse event reporting. There was considerable debate about what should be reported, by whom and when. Most felt that it was difficult to be restrictive at the reporting stage of the process and it was better to encourage early reporting of any adverse event by any suitably qualified person.

This would then allow the "analysis mechanisms" within the risk management structure decide how serious particular incidents are. As adverse events or near misses are eventually considered by the RMC it would be their responsibility to develop reporting rules and regulations in the light of experience.

General principles about adverse events and near misses

- Observation and immediate reporting of deviations from normally expected outcomes should be encouraged. A standard incident reporting sheet should help this.
- Any patient injury or "near miss" should be reported.
- There should be early investigation of serious incidents.
- The RMC and management structure of the trust are responsible for later analysis of trends, formal reports and educational exercises based on the evidence.

Major features of successful incident reporting system

- Investigation of adverse events should not be directly related to disciplinary action but is focused on preventing harm to patients.
- The aims, objectives and policies of the system should be clear to all and there should be appropriate documentation.
- Adverse event reporting will only work within a larger risk management tructure.
- All successful adverse event reporting and risk management systems need to be co-ordinated by an experienced risk manager.
- The system has to be actively encouraged and supported by "leaders" within the Trust e.g. clinical directors, senior nurses, PAM's etc.
- It should be possible to identify certain ocal "trigger events" within specialities that imply a "major" adverse event has taken place and have protocols for further early investigation in place e.g. unplanned return to operating theatre, unplanned endotracheal extubation, death following elective surgery etc.
- Regular adverse event summaries need to be available for the risk management committee of the Trust. Digests of this should be available for all staff.
- If there are particular personal lessons from any event there should be effective staff feedback.

The group felt that risk management and adverse event reporting are essential tools. Implementing these on a successful basis will require cultural changes throughout the NHS. If they are to be useful in implementing the principles of clinical governance there needs to be an investment of time, training and personnel in helping to make it happen.

workshop 2

Clinical and Performance Indicators

Facilitator: **Professor Randal Hayes, Chairman, Clinical Governance Committee, Belfast City Hospital**

Objectives of the Workshop

1. To explore information sources currently available on Clinical Performance Indicators.
2. Discuss the validity of these indicators.
3. Develop an action plan that will allow standardised, quality data to be produced in Northern Ireland.

NHS Performance Assessment Framework

Health Improvement
To reflect the over-arching aims of improving the general health of the population and reducing health inequalities, which are influenced by many factors, reaching well beyond the NHS.

Fair Access
To recognise that the NHS's contribution must begin by offering fair access to health services in relation to peoples needs, irrespective of geography, socio-economic group, ethnicity, age or sex.

Effective delivery of appropriate healthcare To recognise that fair access must be to care that is effective, appropriate and timely, and complies with agreed standards.

Efficiency
To ensure that the effective care is delivered with the minimum of waste, and that the NHS uses its resources to achieve value for money.

Patient / Carer Experience
To assess the way in which patients and their carers experience and view the quality of care they receive, to ensure that the NHS is sensitive to individual needs.

Health Outcomes of NHS care
To assess the direct contribution of NHS care to improvements in overall health, and complete the circle back to the over-arching goal of health improvement.

The Clash of Agendas

- Different stakeholders have different agendas to outcome indicators:

- Managers
- Politicians
- Public
- Clinicians

Aspect	Of interest to
Effectiveness / appropriateness Efficiency	Health professions Funding Bodies
Acceptability / accessibility	Patients and families
Equability / relevance	Government

- Need to be aware of indicators being used as totems or virility symbols in other games.
- Nothing should be allowed to get in the way of the central purpose of improving the quality of patient care.

Clinical Indicators

- Must have a credible relationship with desired outcomes of care
- Need to take into account:
  - accuracy of data
  - case-mix
- Need to be generalised to all units
- Need to use existing information systems and audit methods
- No direct inferences about Quality of Care should be drawn from the indicators
- They are intended to highlight issues which may require further investigations.

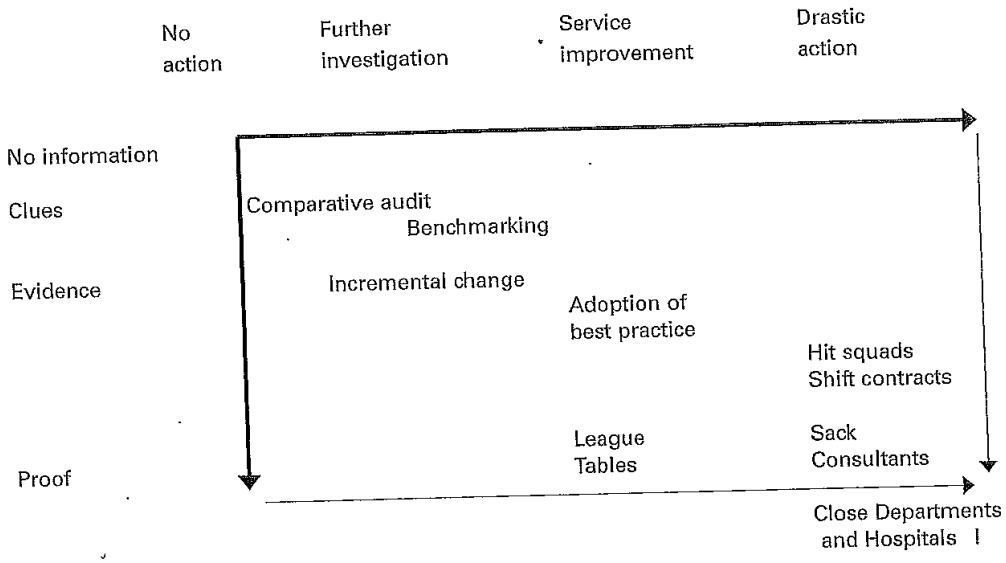
Examples of Data Quality Indicators

- Percentage of patient spells with inappropriate codes e.g. signs and symptoms, in primary diagnosis field
- Average number of coded diagnoses per patient spell (including day cases)
- Percentage of patient spells uncoded.
- Average number of coded procedures per patient spell (including day cases).

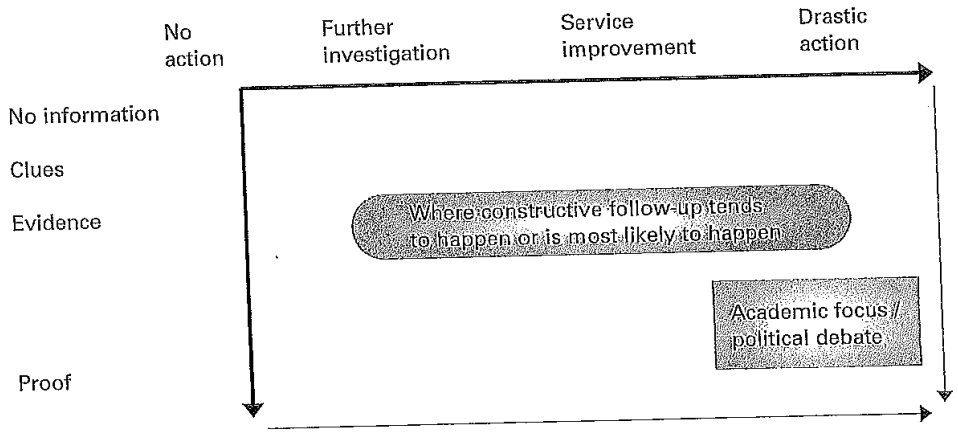
Value of an Outcome Indicator

- An outcome indicator highlights possible sub-optimal performance
- Further investigation confirms that variations in indicator represents a real difference in quality of care
- Further investigation identifies problems:
  - resources
  - method of treatment
  - efficiency of treatment
- Action taken.

The evidence - action space: what fits where



Outcome Indicators - the evidence action space



Making use of the indicators

- The current culture of the NHS is, in the main, not conducive to the kind of collaborative, comparative follow-up needed to make best use of the indicators
- Indicators likely to be most useful in combination with other kinds of evidence: guidelines, audit.
- Aiming for a situation wherein the indicators are seen as an opportunity - not a threat
- Need to shift towards a culture of comparison: e.g. comparative audit, benchmarking aimed at identification and adoption of best practice.

Exercise

Clinical & performance indicators: information requirements

Our group examined the six clinical indicators used in England and Wales. It was agreed that to be useful clinical indicators needed to:

- have a credible relationship with desired outcomes of care
- take into account accuracy of data and case-mix
- be generalised to all units
- use existing information system and audit methods.

None of the suggested indicators met these specifications. However, they could identify problems which required further investigation. On their own they could not provide reliable evidence as to quality of care.

Six indicators used in England and Wales (1998)

- 30 day in-hospital perioperative mortality by method of admission
- 28 emergency re-admissions by NHS hospital of first treatment
- discharge home within 56 days of emergency admission from home with stroke
- 30 day in-hospital mortality for Acute Myocardial Infarction
- discharge home within 56 days of admission with fractured neck of femur by method of admission
- 30 day in-hospital mortality for fractured neck of femur by method of admission.

Proof, Evidence, Clues (questions asked of each indicator)

Q: Do the indicators furnish proof?

No

Q: Do the indicators provide evidence?

Yes, but not conclusive

Q: Do the indicators provide useful clues?

Yes

workshop 3

Evidence Based Practice dissemination, application and monitoring

Facilitators: **Dr Connor Mulholland, Director of Clinical Audit**
Maureen Toner, Clinical Audit Manager
Royal Hospitals Trust

SUMMATION

The development and application of evidence-based practice is an important component of the clinical governance agenda. This workshop was therefore held to discuss the key issues involved and to make recommendations for the way forward.

Participants represented various health care disciplines including nursing, medicine, clinical professions and clinical audit. Discussion focused on identifying the sources of evidence-based information, practical ways of disseminating this information, applying the evidence, the cultural issues involved and practical methods for systematic review. Two case studies provided the opportunity for group participants to debate the issues from a management perspective and from a clinician's perspective.

At the close of the workshop, the following recommendations were agreed:

- Evidence-based practice must be strategically driven from the top.
- Electronic systems required.
- Contractual time for training and development
- A culture of enquiry and accountability needs to be developed.
- Review must be taken through clinical audit.
- A reporting mechanism should be established:
  - Internally
  - Externally
  - Commissioners development.
  - Commission for Health Improvement
  - The public.

workshop 4

Involving the Service User

Facilitators: **Brian Dornan, Director of Community Services**
Tom Ward, Quality Support Manager Down Lisburn Trust

User Groups and Mechanisms

A range of existing and developing arrangements to consult and involve service users were identified. These included:

- Health and Social Services Councils - statutory role
- Patient Participation Groups - developed recently at several GP practices, in at least one instance with the Community Trust as a partner
- Carers Groups
- Friends' Group - organised on the basis of hospitals, homes or other facilities
- Special Interest Groups
- Advocates - in some instances based in Health & Social Services facilities
- Community Consultation Panel - a large panel, drawn randomly from the electoral register, who have agreed to participate in surveys, focus groups etc. on an agreed range of issues or services
- Representation on Planning Groups
- Surveys
- Focus Groups
- Complaints and Comments

Capacity Building

It was recognised that professional and other staff do not generally have skills or expertise in user consultation. Engaging users of service, and using mechanisms identified, requires skills and knowledge. If service users are to be involved meaningfully there is likely to be requirements for:

- skills development through training of staff, and in some instances, of service users
- use of facilitators
- resources, particularly time

Co-operation between Trusts / Practices

There is potential for co-operation between Trusts and between Trusts and GP practices to develop shared consultation and involvement arrangements. In particular acute Trusts may be able to benefit from the links that community Trusts have with their natural communities. There should be particular scope for community Trusts and GP practices to work together to develop common mechanisms.

Achieving real influence

It is important that user involvement is meaningful and challenging. Token involvement will not bring optimum results and will probably lead to disillusion by both users and professionals engaged in the process. Audit results should be stored with users when appropriate and users involved in setting standards. With regard to complaints, the emphasis should be on learning and outcomes, not on process. 'Cosy' arrangements in which user representatives do not challenge are of limited value. Above all we should ensure that where involvement is through representation that representation is where it matters, where influence can be exerted.

Group Feedback

Increasing Capacity:

- Skills - training:
  - staff
  - service users
- Role of facilitators
- Resources - time

Range of User Groups / Mechanisms

- Community Consultation Panel
- Patient Participation Group
- Special Interest Groups
- 'Friends' Group
- Carers Group
- Advocates
- Focus Group
- Representation on Planning Groups
- Complaints
- Surveys
- Health & Social Services Councils

Give Real Influence

- Audit - standard setting
  share results
- Complaints - emphasis on learning and outcomes - not process
- Not too cosy
- Representation where it matters - where influence is possible.

workshop 5

Integration of key components for Clinical and Social Care Governance

Facilitator: **Dr Tom Trinick, Lead Clinician for Clinical Governance**
Lorna Telford, Quality Manager
Ulster Community and Hospitals Trust

The Problem:

- too many meetings
- meetings allowed to overrun
- the same people attend multiple meetings
- too many committees
- old structures may not be discarded as new structures introduced
- unclear remits for committees, no clear vision, no future plan.

Communications:

- staff usually meet and are informed through the clinical directorate and program of care route (promote a no blame culture)
- in addition hold general meetings, publish news sheet, web page on Intranet.

Complaints:

- close the loop
- learn lessons across departments
- computer software may spot trends (cost is often a feature).

Reduce Committees: (barrier if too many involved)

- focus through clinical governance (committee, department, support group)
- regular reports to the central group
- agenda item at Clinical Governance or Primary Care meeting
- build into business plans
- clear remits, responsibilities
- people on committees need to be responsible - otherwise support
- lifelong learning
- interface issues between primary and secondary care.

Issues for Discussion

- identification of quality systems already in place. These include:
  - complaints
  - risk management
  - quality
  - audit (uni- and multiprofessional)
  - continuous professional development
  - appraisal.
- the potential benefits of integration - areas where integration is realistic (SWOT analysis)
- barriers to integration and methods to remove the barriers.
- possible approaches to auditing governance.

workshop 6

Clinical Governance in General Practice

Facilitator: **Dr A Farooqi, East Leicester Medical Practice**

The group included representatives from South & East Primary Care Group. North & West Belfast Total Purchasing Pilot, North Down Primary Care Organisation, The Eastern Multifund, Donard Commissioning Group, Lisburn Commissioning Group, Northern Ireland Council for Postgraduate Medical & Dental Education, Royal College of General Practitioners and the Eastern Health & Social Services Board GP Audit Team and GP Unit.

Summary of points raised:

- We are not starting from scratch - activity is already going on in practices

Need to establish a baseline of activity taking place in practices e.g. audit, or devise some sort of a benchmarking measurement.

- Encourage engagement of individuals in Clinical Governance and not just the practice/organisation.
- There is a daunting agenda
  - › one step at a time
  - › organisational development important
- Resources are an issue that needs addressed
  - › lobby
  - › make your case for patient care
- Resources and priorities
  - › need to be aware of the priorities of "others" and the broader agenda - e.g. patients, DHSS&PS, professional groups
- Importance of a "no scapegoat" culture
  - › openness
  - › break down boundaries
  - › need for cultural change, overcoming GP fears of "exposing" their practice
- Learn, improve, prevent
  - › mentors
- Locally agreed and informed ownership
- Be proactive, close the loop.

Some Barriers & Issues

- IT and information available in practices
- Engaging GPs in Clinical Governance - revalidation may be a lever.
- The underperforming GP - what are the mechanisms for detection and what are the markers?

appendices

appendix 1

Listing of Posters and Demonstrations

- **GP Audit Team, Eastern Health and Social Services Board**

  Audit of Management of Paediatric Urinary Tract Infection
  Child Protection - GP Input into the Case Conference Process
  Contact [redacted], GP Audit Team,
  EHSSB, 12/22 Linenhall Street, Belfast BT2 8BS or Tel: [redacted]

- **Green Park Healthcare Trust**

  User Involvement Strategy
  Orthopaedic Outcomes Audit
  Quality Review
  Seating Audit, Care of the Elderly Directorate - NI Regional Audit Prize

  Contact [redacted] Director of Patient Services, Green Park Healthcare Trust,
  Musgrave Park Hospital, Stockmans Lane, Belfast. Tel [redacted]

- **Mater Hospital Trust**

  Integrated Care Pathway for Acute Exacerbation of Chronic Obstructive Pulmonary Disease
  Contact [redacted] Respiratory Nurse, Mater Hospital Trust,
  Crumlin Road, Belfast. Tel [redacted]

  Integrated Care Pathway for Suspected Unstable Angina
  Contact Staff Nurse Catherine Bligh, Coronary Care Unit, Mater Hospital Trust

  Audit of Thromboembolic Prophylaxis in Caesarean Section and Gynae Surgery
  Contact [redacted] Clinical Audit Department, Mater Hospital Trust

  Community Forum
  Contact [redacted] Community Liaison Officer, Mater Hospital Trust

- **The Royal Group of Hospitals Trust**

  The Development of Multiprofessional Care Pathways as a means of Improving Efficiency and Promoting Evidence-based Practice

  Contact [redacted] Care Pathways Co-ordinator, 1st Floor, Bostock House,
  The Royal Hospitals, Grosvenor Road, Belfast BT12 6BA. Telephone: [redacted]

appendix 1

- **Belfast City Hospital Trust**

  Utilising 'Access' software to support Clinical Governance
  Contact: [redacted] IT Support, Belfast City Hospital Trust,
  Lisburn Road, Belfast. Tel [redacted]

  How the Intranet can contribute to Clinical Governance
  Contact: [redacted] IT Support

- **Down & Lisburn Health & Social Services Trust**

  Multi-disciplinary Pathway of Care for cardiac patients
  Contact: [redacted] Senior Staff Nurse, Coronary Care Unit or
  [redacted] Coronary Care Unit, Lagan Valley Hospital, Lisburn.

  The Home Care Agency: Using focus groups - What, Why, How, When and Where ..
  Contact: [redacted] Acting Home Care Agency Manager,
  Down Lisburn Trust, Lisburn Health Centre, Linenhall Street, Lisburn.

  Mental Health Services: Seclusion Audit - Kilclief, Downshire Hospital
  Contact: [redacted] Staff Nurse, Kilclief, Downshire Hospital, Downpatrick,
  Co. Down. Tel [redacted]

  Disability Services - Involving Users of the Services
  Contact: [redacted] Operations Manager Residential & Day Services,
  Down Lisburn Trust, Lisburn Health Centre, Linenhall Street, Lisburn.
  Tel [redacted]

- **North & West Belfast, Health & Social Services Trust**
  Promoting User Involvement in Health and Social Care - North & West Belfast Health & Social Services Trust's Public Workshop and Focus Group Process

  Contact [redacted] Community Development Team Leader, North & West Belfast HSS Trust, "Grovetree", 106 Collingtree Road, Belfast BT12 4BA. Tel: [redacted]

- **Queen's Medical Library**

  The Medical Library is the central library for all Health and Personal Social Services in Northern Ireland. It also provides a service to anyone eligible to use the Queen's University Library, particularly those in the Faculty of Medicine and Health Sciences. It is situated in the Institute of Clinical Science building within the grounds of the Royal Victoria Hospital. The Medical Library makes available a range of electronic information resources. Where possible, it makes these resources available on the World Wide Web so they can be accessed easily from any location, whether that be the Library, the desktop or the laptop.

  Contact: Information Services, Queen's Medical Library, Clinical Institute Building, Royal Hospitals Trust, Grosvenor Road, Belfast. email: med.info@qub.ac.uk

appendix 1

- **South & East Belfast Health & Social Services Trust**

  Poster - Learning and Development Strategy

  Video - Person Centred Information System (PCIS)

  Contact: [redacted] European Office, South & East Belfast Health & Social Services Trust, Knockbracken Health Care Park, Saintfield Road, Belfast.
  Tel [redacted]

- **Ulster Community & Hospitals Trust**

  Path Finder - Demonstration
  Contact: [redacted] Project Manager
  Ulster Community & Hospitals Trust, 3 Church Street, Newtownards, BT23 4AN.
  Tel [redacted]

  The Ulster Hospital is a member of the National Pathfinder Consortium which comprises 14 member Trusts UK wide. Members are committed to developing and promoting the Pathfinder system. Pathfinder is a clinically led, locally managed computer healthcare information system. The aim is to improve patient care by providing easy access to up-to-date clinically useful information which is relevant locally.

appendix 2

Eastern Area Health & Social Services Board:
Area Audit Committee Membership

[redacted]

Down Lisburn Health & Social Services Trust

North & West Belfast Health & Social Services Trust

South & East Belfast Health & Social Services Trust

Royal Group of Hospitals Trust

Downshire Hospital

Down Lisburn Health & Social Services Trust

Ulster Community & Hospitals Trust

Belfast City Hospital Trust

Royal Group of Hospitals Trust

North & West Belfast Health & Social Services Trust

Eastern Health & Social Services Board

Belfast City Hospital Trust

Ulster Community & Hospitals Trust

North & West Belfast Health & Social Services Trust

Ulster Community & Hospitals Trust

North & West Belfast Health & Social Services Trust

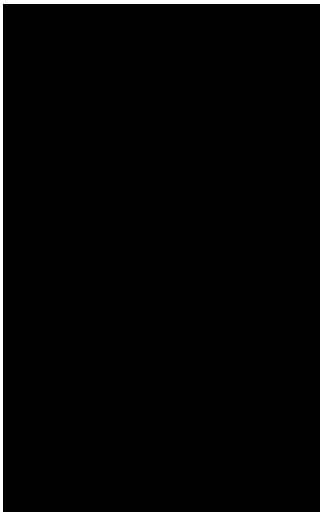
General Practitioner

General Practitioner

General Practitioner

General Practitioner

appendix 2



General Practitioner

Eastern Health & Social Services Board

Mater Hospital Trust

General Practitioner

Belfast City Hospital Trust

Ulster Community & Hospitals Trust

General Practitioner

Down Lisburn Health & Social Services Trust

appendix 3

Addresses of Trusts

Eastern Health & Social Services Board
12/22 Linenhall Street
Belfast BT2 8BS

Belfast City Hospital Trust
Lisburn Road
Belfast BT9 7AB

Down Lisburn Health & Social Services Trust
Lagan Valley Hospital
39 Hillsborough Road
Lisburn
Co Antrim BT28 1JP

Green Park Healthcare Trust
Musgrave Park Hospital
Stockmans Lane
Belfast BT9 7JB

Mater Hospital Trust
Crumlin Road
Belfast BT14 6AB

North & West Belfast Health & Social Services Trust
Glendinning House
6 Murray Street
Belfast

South & East Belfast Health & Social Services Trust
Knockbracken Health Care Park
Saintfield Road
Belfast

The Royal Group of Hospitals Trust
Grosvenor Road
Belfast BT12 6BA

Ulster Community & Hospitals Trust
Upper Newtownards Road
Dundonald
Belfast BT16 0RH