Greater Glasgow and Clyde NHS Board

Board Meeting

Tuesday 23rd June 2009 **Board Paper No. 2009/27**

Medical Director

MID STAFFORDSHIRE FOUNDATION TRUST

Recommendations:

The Board:

The Board is asked to note the response provided to Dr Woods following his letter of 31st March. His letter was a follow-up to the Healthcare Commission's report on Mid Staffordshire NHS Foundation Trust.

He provided a framework to act as the basis for a local review and asked that a report be submitted by the end of April 2009. We extracted the key points from his letter and both Dr Woods' letter and the Board's response are provided.

RESPONSE TO FOLLOW-UP TO THE HEALTHCARE COMMISSION'S REPORT ON

MID STAFFORDSHIRE NHS FOUNDATION TRUST

The key points from the framework provided on 31st March 2009 are listed together with our responses below.

1. *Does the Board have regard to the NHS QIS standards on clinical governance and risk management?*

The corporate focus and approach to NHS QIS Clinical Governance and Risk Management Standards is embedded in the Board's Clinical Governance strategy. The implementation approach is based on a scheme of allocated corporate, or in a few instances, devolved management responsibility for core areas in alignment with prevailing accountabilities. Monitoring of progress is accomplished through internal self-assessment undertaken by the Head of Clinical Governance, but accountable to the Medical Director as Executive lead. Reports are highlighted through the Board Clinical Governance Implementation Group and linked into HEAT reports and Board accountability reviews. We are currently advancing fuller organisational self-assessment as part of NHS QIS standards peer review.

We believe that we have sufficient regard to the NHS QIS Clinical Governance and Risk Management Standards, and have appropriately integrated the principles and standards into the way we work.

2. *Have we ensured that the Board's clinical effectiveness strategy is fit for purpose?*

In interpreting this question, we have considered the following key questions.

Does the Board clearly express its expectation of responsibilities where there is information indicating potential sub-optimal care?

Are there robust monitoring arrangements that ensure such concerns are adequately resolved?

NHS GG&C make a number of statements in key organisational documents that inform the response to these questions. The Board has a set of Transformational themes that underpin the vision of the organisation and are embedded in the performance management system for all senior staff. The set contains the following point that we expect NHS GG&C to be "*An organisation where people take responsibility for their area of work and for the wider performance of the organisation".* This statement personalises the expectation that all staff have responsibility for addressing performance concerns whether they are part of their own accountabilities or not.

The recently revised Board Clinical Governance Strategy contains the statement that NHS GG&C Headquarters hold responsibility for:

- ensuring that all services respond fully to concerns of sub-optimal care including appropriate communication on investigation and improvement processes to general management, and corporate assurance arrangements.

It also the states that "within NHS GG&C, the Acute Services Division and Care Partnerships have responsibility to":

- make sure all services comply with the statutory requirements and duties with reference to appropriate national standards for clinical governance and patient safety (including those commissioned from contractors or jointly provided with other organisations)

- make clear the joint accountability for services which are provided on a multi-agency, multi-sector basis, and involve partners in service provision within clinical governance activities

- make clear the accountability for key organisational risk and functions associated with their services

- demonstrate ways of working that systematically improve the safety, quality and responsiveness of clinical practice and services

- develop an open and just culture within the organisation where incidents are reported and lessons are learned

- ensure that any emerging concerns over the quality and safety of care or services are fully reviewed and appropriate improvement plans are established, monitored and communicated

- involve all clinicians in regular clinical audit and review of practice and services, including full participation in national confidential enquiries, audits or improvement programmes

- apply key clinical quality and clinical outcome measures in local monitoring arrangements

- maintain processes of professional support and learning which sustains staff knowledge and competence and detects, then responds to concerns of capability or performance

- maintain reporting arrangements to the Director and the Health Board on clinical governance activities".

The Board Risk Register Policy is currently being subjected to consultative review and contains clear directions for staff on the escalation of risk that cannot be adequately controlled within local management systems. The new version will also contain a stronger statement on the retention of responsibility, until a risk is formally transferred or escalated e.g. where risk control may be shared or identified by one service, but management control is located in another area.

The Board has also made changes to individual job descriptions to ensure that there is specified accountability for the detection and response to indications of quality and safety failures. For instance, the job description for Chairs of our Cancer MCNs makes this explicit and also requires that they directly inform the Chief Executive when these situations are perceived to arise.

The Board Medical Director has the first agenda item at every Clinical Governance Committee to identify significant clinical incidents or serious service concerns to the Committee, ensuring that it is appraised both of investigation and all remedial action, and that this reporting is maintained until the Committee is satisfied that all improvements have been secured.

It is also important to recognise the role of culture in addressing such situations. It is apparent that Executive Directors and other senior staff are extremely sensitive to both formal and informal expression of concerns. Where concerns are informally raised, they will ensure the matter is appropriately addressed and emphasise the need for openness to prevent inappropriate suppression of information. Another key factor is engagement with clinical communities which, if it is absent, can limit improvement progress. As an example, in our review of the most recent surgical profile, we identified an outlier in one hospital. In our feedback report, the management team supported an exploration of the indicator and associated information, but did not allow a discussion on data quality to deflect from the opportunity to establish an improvement plan.

We perceive that the policy, practice and culture of NHS GG&C is consistent with an organisation that has ensured its staff are aware of responsibilities surrounding the communication, detection and response to concerns over the quality and safety of care.

3. *Does the Clinical Governance Committee (and, indeed, the Board as a whole) have the skills and capability necessary to challenge appropriately the Board's clinical performance, not just in acute care but also in primary care, across mental health services?*

The Clinical Governance Committee is made up of non-Executive members, but supported by Executive Directors and other senior staff in an ex-officio capacity. The purpose of ex-officio support is to ensure that interpretation and interrogation of the presented information by the Clinical Governance Committee is aided by the expertise of the organisation. We have held a number of discussions within the Committee about its role and purpose that included a focus on the preparedness of individual members to serve on the Committee. We have also undertaken informal sessions to explore with individual members, expectations of the organisation's performance. The Clinical Governance Committee has also been subjected to a review by our internal auditors to ensure that members, individually and collectively, are operating appropriately and are being supported in doing so by the organisation. We have, as a result on these ongoing reviews, developed specific guidelines for individual services when presenting to the Clinical Governance Committee to ensure that key issues and responses from the Clinical Governance Committee are apparent. We have more recently, through the Head of Clinical Governance, started to look at introducing the principle of critical questions into the way the Committee receives update reports as an additional means of ensuring that the key issues within any report are prominent to the reader.

In addition to the Board and its mandatory Committees, we operate regular Board seminars to ensure that there are additional opportunities to explore specific issues in greater detail, allowing fuller education on complex matters for Board members, Executive Directors and other Senior Officers.

It is apparent that the Board is mindful of the need to ensure that Executive and Non-Executive Directors have the appropriate skills and capabilities to challenge and ensure the performance of the organisation is acceptable. It is clear from our own observations of the conduct of the Board and its Committees that this is the case. However, in considering the support to Non-Executive Directors in particular, we would ask that SGHD work with QIS to develop further their Clinical Governance Committee and Non-Executive Network. In addition, although we are conscious of a number of internal discussions exploring the theme of Non-Executive capability, we are also unaware of any formal external evaluation of Non-Executive perceptions of their own ability, and think that this may be extremely helpful in providing more targeted educational support.

In addition the report should cover the following issues;

a) *What action is the Board taking to track Mortality Rates in the Board area, such as Standardised Mortality Ratio (SMR) in individual hospitals and in primary care?*

To our knowledge, ISD have not yet established a routine systematic arrangement for the dissemination of standardised hospital mortality ratios. A set of HSMR results were produced in January and made available through Chief Executives, but this identified only one of our seven acute hospitals. Raw mortality data is being gathered and being considered through the Scottish Patient Safety Programme, however, the lack of standardisation or comparison considerably limits the opportunity to apply this information in identifying and responding to concerns about unacceptable performance.

Through the Board Medical Director, who is the Executive Lead for patient safety, along with the SPSP Implementation arrangements and the Board Patient Safety Group, we will be considering more fully the factors that contribute to hospital mortality, but placing particular emphasis on developing intervention strategies that seek to reduce mortality levels. The Board is very supportive of the use of surgical profiles and supporting information such as SASM to review mortality rates within the surgical specialties. You can see from the NHS GG&C response to the most recently published surgical profile, that we have investigated and followed up any identified outliers within the Scottish data set. We also have a further set of arrangements within the Surgery & Anaesthetic Directorate where, as part of their clinical governance arrangements, they have established local mortality reviews to identify whether there where any learning points arising from the death of surgical patients that would improve the safety of our services.

b) *What action is the Board taking to track Infection rates?*

Within NHS Greater Glasgow & Clyde, the NHS Board and associated committees, track infection rates through the following reports and processes:

- The NHS Board receives bi-monthly Infection Control reports which include data on MRSA Bacteraemias, C-diff, Staph Aureus Bacteraemias, Surgical Site Infections,

Hand Hygiene and cleaning services. This report is also reviewed by the Board Clinical Governance Committee.

- The functional directorates within the Acute Operating Division receive monthly reports which include statistical process control charts for MRSA Bacteraemias and C-diff. Hand Hygiene audits, audit of the patient's environment and a summary of actions taken where exceptions have been reported. These reports are also made available to the individual ward and departmental managers.

- The Acute Directors receive quarterly reports on surgical site infections in accordance with the HPS Mandatory Surveillance Programme.

- The NHS Board monitor trends of deaths recorded by GRO as having a primary cause of Clostridrium Difficile.

- The minutes of the Board Infection Control Committee are reviewed at each meeting of the Clinical Governance Committee, together with a summary of key points for the Governance Committee to note.

c) What process is in place for the Board to consider incident reports?

The Board has an established Significant Clinical Incident Policy which places a responsibility on all our services to identify any high consequence events or potential high consequence near miss events, ensuring that these are suitably investigated with a focus on establishing improvement points and options for services.

All such events are linked into the services Clinical Governance Forum which is then responsible for ensuring the adequacy of investigation, the establishment of an action plan and the communication of appropriate information to clinical teams. A number of these events, which are considered of greatest significance in terms of consequence for patients, indications of concerns about services and major opportunities for service improvement, will be linked through strategic reporting arrangements on an individual case basis. These are processed through clinical governance arrangements and will be linked through the Board Medical Director to the Clinical Governance Committee at each meeting.

NHS GG&C has a number of dedicated patient safety staff within the Clinical Governance Support Unit who provide expertise and specialist support around individual events, but in particular, in the analysis of cross-cutting themes and issues that identify much broader learning opportunities for the organisation as a whole. Such items are linked into the strategic improvement plans for clinical governance and risk management and will be the subject of communication to services through a range of educational opportunities or organisational bulletins. Trend analysis from incident reporting arrangements occurs both in the organisation as a whole through the Incident Reporting Steering Group with links to the Board Risk Management Steering Group, and for patient safety issues, through Clinical Governance Forums. We are in the middle of implementing a new incident reporting system which allows direct access to the database of incident reports, and this has facilitated a significant increase in local services to undertaking their own trend analysis.

The Head of Clinical Governance has also recently initiated a project that seeks to extract a set of patient safety indicators from the incident reporting arrangements and establish these within the performance management arrangements.

d) How does the Board receive reports on complaints and negligence claims?

Complaints

A Quarterly Complaints Report is submitted to the NHS Board which is in the public domain (and has been for many years). This report identifies:

- the number of complaints received in that quarter;
- the number of complaints completed in that quarter;
- the performance against the national standard of completing 70% of complaints within 20 working days;
- the number of completed complaints upheld, upheld in part and not upheld;
- the number of requests for conciliation;
- the number of complaints which were deemed irresolvable, withdrawn or declared vexatious;
- the number of completed complaints within Acute and the Partnerships as per the ISD Complaint Categories.

In addition, the Quarterly Complaints Report identifies the main trends across the Acute Services Division and the Partnerships (including Mental Health Partnership), and specific service improvements are shown across NHS Greater Glasgow and Clyde which have resulted from complaints.

The report identifies ongoing local and national developments in connection with complaints policy/procedures and recently, we now have included the statistics in relation to the number of health cases/enquiries received by the Independent Advice and Support Service (Citizens Advice Bureaux).

When relevant, the Quarterly Complaints Report will include extracts from the ISD Annual Report and Ombudsman's Annual Report and highlight NHS Greater Glasgow and Clyde's performance against the rest of Scotland.

Lastly, the Complaints Report identifies the Ombudsman cases from each Monthly Compendium for the quarter covered by the report and provides a précis of each case together with a description of the recommendations in each case. The Clinical Governance Committee thereafter has a responsibility, on behalf of the Board, to ensure that each recommendation is implemented in the interests of effective and safe care delivered to our patients and to ensure that where lessons learned require to be disseminated across the organisation, this is carried out. The NHS Director General and

the Ombudsman's Office are also advised within particular timeframes of the steps taken to implement each recommendation.

In relation to the above, the Clinical Governance Committee reviews quarterly each Ombudsman recommendation and the management action undertaken.

The Performance Review Group receives as part of the Quarterly Performance Report the performance in handling complaints against the national target of 70% of complaints completed within 20 working days.

Legal Claims

Currently there is no direct reporting to NHS Board Members on the handling and settlement of legal claims, including clinical negligence claims.

On receipt of a legal claim/summons, this is copied to the relevant Director, General Manager and Clinical Director, in order to draw their attention to the potential claim and any action they may require to undertake including providing the Central Legal Office with any paperwork/clinical records sought.

The Datix system is used to capture legal claims and a Claims Report is compiled highlighting all live claims within each Directorate by specialty and hospital. A similar report on new claims intimated, as well as the settlement of claims, is also provided for each quarter. Meetings are held with Directors with, on occasions, the presence of the Medical Director/Nursing Director to go over the relevant Claims Report.

The vast majority of legal claims relate to the Acute Services Division, and with the appointment of a new Head of Administration – Acute Services now being made, consideration can be given urgently, if required, to devising an appropriate reporting mechanism to NHS Board Members on the handling of all legal claims.

e) *What arrangements are in place for the Board to track absence rates and vacant posts?*

Absence rates in NHSGGC are monitored both locally and at Board level. Each month local HR teams are issued an Excel report detailing absent employees within their Directorate/CHP/CHCP. This information is downloaded from Empower, which is in turn fed by Payroll. When the report has been received, local HR teams will take forward any appropriate action with the line manager of those concerned.

At Board level, the absence rates are communicated at the quarterly Staff Governance Committee. The report is complied by the Head of HR Projects, and details current absence rates as well as an analysis of how the current rate compares to different periods throughout the year. The statistics are also broken down into local Directorates and Partnerships.

NHSGGC fill approximately 5000 posts each year. Each part of the organisation has delegated authority to fill vacancies as they arise. It is the responsibility of each employing manager to make arrangements with the Central Recruitment Team to advertise the post and commence the recruitment process. In some cases, a post will not attract any

applications, and at this point the Recruitment Team will liaise with the manager to re-advertise the post. It is also standard practice in NHSGGC to send all vacancies to the Central Redeployment Team for review, prior to it being advertised. This ensures that any posts suitable for individuals currently awaiting redeployment will be 'ring fenced' before going to advert. The Head of Resourcing has overall responsibility for recruitment in NHSGGC and is supported by a Recruitment Manager, who has operational responsibility.

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The Scottish Government

NHS Board Chief Executives

Homecoming Scotland 2009

31 March 2009

Dear Colleague

FOLLOW-UP TO THE HEALTHCARE COMMISSION'S REPORT ON MID STAFFORDSHIRE NHS FOUNDATION TRUST

At the Chief Executives meeting on 18 March, I briefed you on the above report and I asked you to review the adequacy of your local arrangements to detect and act on serious shortcomings in standards of care.

I am writing to provide a framework for your local review and to ask you to let me have a report on your findings by the end of April 2009. Those reports will then feed in to work which I have asked the Scottish Government Healthcare Policy and Strategy Directorate to undertake to develop a common set of measures that we can use across NHS Scotland to provide an alert of service deterioration. In parallel, the Chief Medical Officer will discuss with Medical Directors what measures might be appropriate. Once concluded, my expectation is that NHS Boards will use this data in a consistent way to identify potential problems, and assist them to fulfill their important scrutiny role.

In carrying out this review, I expect Boards to have regard to the NHS QIS standards on clinical governance and risk management. You will wish to satisfy yourself that the Board's clinical effectiveness strategy is fit for purpose and that your Clinical Governance Committee (and, indeed, the Board as a whole) has the skills and capability necessary to challenge appropriately the Board's clinical performance, not just in acute care but also in primary care, across mental health services, and so on. I should welcome your assurance on those basic points as you report back.

More specifically, I should like the report to cover the following issues;

- What action is the Board taking to track Mortality Rates in the Board area, such as Standardised Mortality Ratio (SMR) in individual hospitals and in primary care?
- What action is the Board taking to track Infection rates?
- What process is in place for the Board to consider incident reports?

- How does the Board receive reports on complaints and negligence claims?
- What arrangements are in place for the Board to track absence rates and vacant posts?
- In all of the above, what is the level at which reports to the Boards are considered – i.e. Board level, Hospital level, Ward level etc?

I should also be grateful if you would let me know of any other approaches or innovations that you have in place to provide yourself with up to date information about clinical effectiveness and about the quality of patient care/ experience in your area.

I look forward to hearing from you. If you have any questions about what is required, then Derek Feeley or Colin Brown will be able to help you.

Yours sincerely

KEVIN WOODS