

Greater Glasgow and Clyde NHS Board

Board Meeting

April 2015

Board Paper No. 15/14

Organisational Review – Proposals for Future Organisation of Clinical Governance

Purpose

- The purpose of this paper is to set out the clinical governance arrangements for NHS GGC following the new organisational structure within the acute sector in GGC and the implementation of 6 Health and Social care partnerships (HSCPs).
- The paper will specifically focus on the level of GGC board wide support and the associated reporting arrangements including the board clinical governance framework and other major policies such as the management of significant clinical incidents.

Board members are asked to note these new arrangements

1. Current position

1.1 Clinical Governance is the term commonly used to refer to the Duty of Quality which is established in The Health Act 1999 and requires that the Board and Chief Executive of NHS GG&C “put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals”. The Duty of Quality applies to all services in connection with the prevention, diagnosis or treatment of illness. It includes services that are jointly provided with other organisations. The major areas of activity include: clinical safety and quality improvement, clinical effectiveness, person centred care and monitoring/assurance functions.

1.2 The NHS GG&C Board, and in particular the delegated role and responsibilities of the Quality and Performance Committee (a Non-Executive body) is currently responsible for maintaining oversight of the quality of care provided through Board services, either directly or commissioned. The Quality and Performance Committee, on behalf of the Board, provides the internal assurance statements that NHS GGC is meeting the statutory Duty of Quality, set by The Health Act 1999.

1.3 The existing Board Clinical Governance Forum is responsible for oversight and strategic coordination of priorities and programmes aimed at improving and assuring safe, effective, person-centred care. It oversees the work of the acute clinical governance forum, the partnership clinical governance forum and the mental health clinical governance forum. There is an extended structure of clinical groups operating in support of these strategic forums.

1.4 The Clinical Governance Support Unit (CGSU) was created in 2005 and is a corporately provided facility to support clinical quality improvement and governance. The unit was initially organised around two key specialist functions of clinical improvement and clinical risk. Staffing/resources are linked to the three

main organisational domains of support: Corporate, Acute and Partnerships. The main aims of the unit have developed to include:

- Maintaining administration of systems for dissemination of clinical standards and regulation of clinical guidelines
- Supporting design and delivery of clinical improvement projects including the mandatory national programmes linked to SPSP and the Person Centred Health & Care Collaborative.
- Developing clinical risk management systems and supporting services clinical risk processes
- Providing guidance and support to clinical leads and clinical governance forums in the analysis of clinical quality, the formulation of improvement priorities and plans, the strategic coordination of improvement support and the translation of monitoring activities to corporate forums for assurance purposes.
- Supporting corporate structures in policy, strategy and the governance of clinical quality

2. Drivers for change

2.1 In December 2013, a working group comprising clinicians and managers was set up to review the range of structural changes as well as both external and internal drivers which may affect the development of clinical governance across primary, secondary and mental health services. Some of the external and internal challenges are summarised in box 1:

Box 1: External and Internal Challenges

External

- The vulnerability to major service failure in UK (Mid-Staffordshire Report, Francis Inquiry)
- Limitations in effectively applied organisational learning and improvement approaches in UK (Berwick Report)
- Acute Hospital Mortality Ratios in UK (Keogh Report, Dr Fosters)
- The levels of harmful adverse events in UK (professional literature)
- Concerns on the governance and oversight of clinical quality in Scotland (HIS report into NHS Lanarkshire and NHS Grampian)
- Maximising the contribution of clinical leadership in UK (NHS leadership reports, McKinsey)
- The increasing use of inspection and other external scrutiny processes in Scotland (HIS consultation)
- The need for greater transparency, assurance and oversight involving Non-Executives (HIS)
- The need to review, reflect and act on patient feedback in respect of issues of safety, quality and patient experience (SGHD)

Internal

- The need to accelerate the pace of transforming healthcare quality (e.g. rate of spread of SPSP elements)
- The outcome of the Vale of Leven Hospital Inquiry report
- The challenge of reliability in quality (OPAH inspection reports, SCIs and adverse event rates, Complaints, Patient Feedback)
- Improving the the quality of patients experience (Francis Report Gap Analysis)
- Limitations in access and application of clinical data for improvement, which can inform other needs including corporate assurance, professional revalidation, external regulation (HIS report into NHS Lanarkshire, NHS GG&C Clinical Governance Framework, Organisational Review paper).
- The desire for greater openness and transparency of decision making within shared governance framework (Francis Report Gap Analysis)
- The need to improve levels of clinical engagement throughout NHS GG&C (Staff Survey)
- Limited efficacy of some traditional forms of clinical improvement activity

2.2 The advent of HSCPs necessitated a complete review of governance arrangements. NHS GGC board approved a scheme of delegation in January 2015. This set out a clear basis for delegation and assurance with clear lines of sight back to the NHS Board statutory responsibilities: this included governance across clinical quality and safety. The relevant extract from the scheme of delegation is set out below:

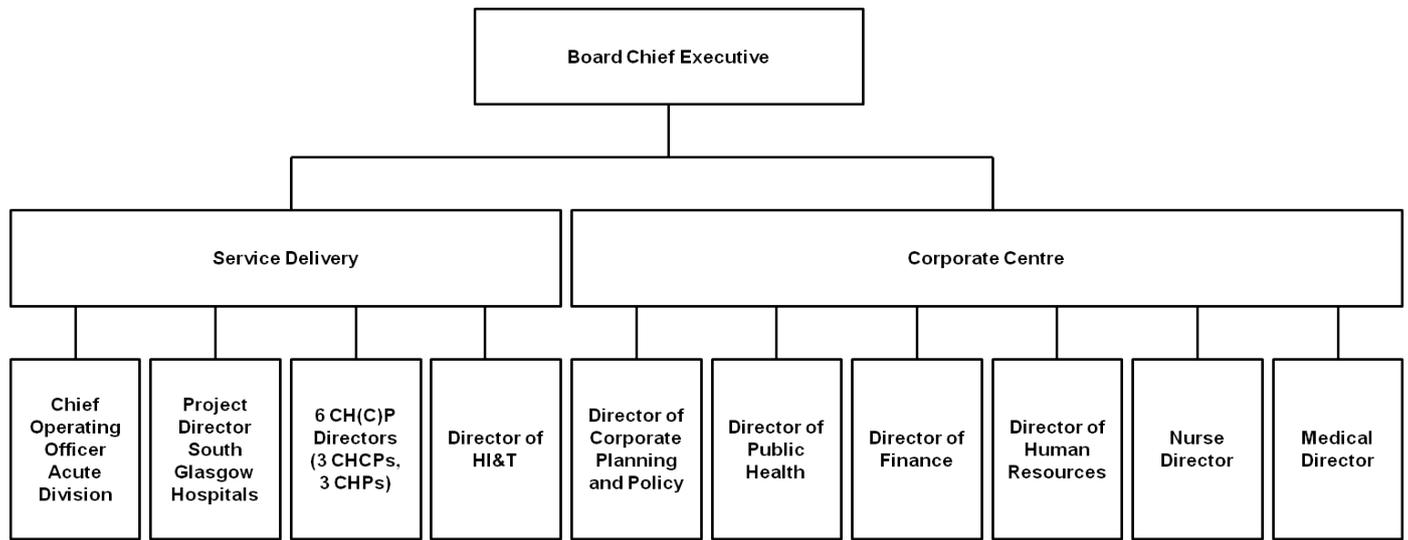
The Board Chief Executive is responsible for clinical governance, quality, patient safety and engagement, supported by the Board's professional advisers. This responsibility is delegated to each Chief Officer. COs and their IJBs need to establish appropriate arrangements to discharge and scrutinise those responsibilities and to link to Board wide support

and reporting arrangements including the systems for reporting of serious clinical incidents. The Board Medical Director is responsible for the systems which support the delivery of clinical governance and medicines governance, those arrangements including the clinical governance unit and the processes which underpin it remain unchanged.

2.3 There is a requirement for HSCP, through their governance arrangements, to establish formal structures to link with the clinical governance structures of the health board as well as local authority governance structures. The most detailed description of responsibilities is laid out in the NHS GG&C Clinical Governance Framework though we expect that local arrangements will be developed in due course. However in order to progress the overall arrangements, it is important that the clinical governance structures at health board level are set out together with the different levels of reporting and assurance to reflect the areas where the board retains direct responsibility for services and the areas where the responsibility will be delegated to chief officers.

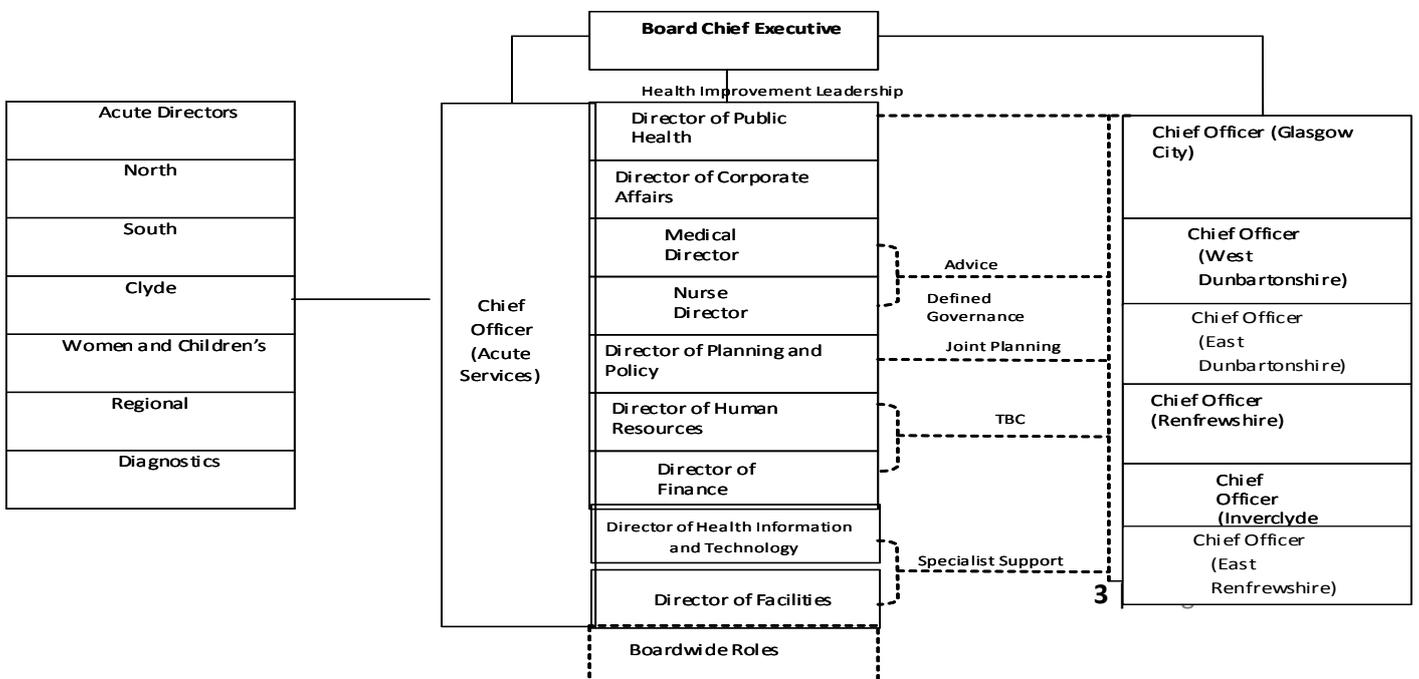
2.4 The board Chief executive set out the need to change structure for acute care within NHS GGC due to the opening of the new south Glasgow university hospitals. In addition, there was a need to ensure a greater geographical focus to ensure better links with HSCP partnerships. There was a move from 6 functional directorates to the establishment of three geographic directorates with three Directorates based on common function and working relationships. Figure 1 below shows the current structure

Current structure to June 2015



Future structure from 1st June 2015

Revised Structure



2.5 Following clinical and management engagement, discussion papers were developed for each of the three major clinical service areas (Acute, Partnerships, Mental Health). These papers set out the current position together with the future changes and describe proposals to change the clinical governance arrangements. The planned improvements have been discussed with senior managers and clinicians.

2.6 During the course of this engagement process, a number of key themes emerged. These are detailed below.

- A key role of clinical governance will be assuring consistent standards and maximising shared learning in cross system working.
- Clinical governance should become increasingly data driven with stronger links to HIT and the new Centre for Data Intelligence.
- The development of the electronic patient record should be evolved to better support the governance of clinical quality.
- Building quality improvement capability and support to Clinical Leads and General Managers should be a greater priority.
- We should establish strategic quality improvement support through a core team of multidisciplinary expertise with networks to services and key stakeholders such as HIT.
- The supporting resources are finite and should be more effectively targeted around agreed strategic priorities using the most effective improvement methods.
- There should be regular planned monitoring of the effectiveness of local CG arrangements.
- The involvement of service users should be integral in all improvement and clinical governance forums and the opportunities provided for them to work in partnership with service staff to co-design and coproduce improvements
- The integration of those functions which have bespoke governance arrangements, such as professional regulation led by Executive Directors, infection control, medicines management and child protection needs to be meaningfully developed within the clinical governance framework.
- Greater oversight will be required to ensure that no key priority is lost or dropped in the transition.

3. Proposals for changing the clinical governance structure and process across GGC

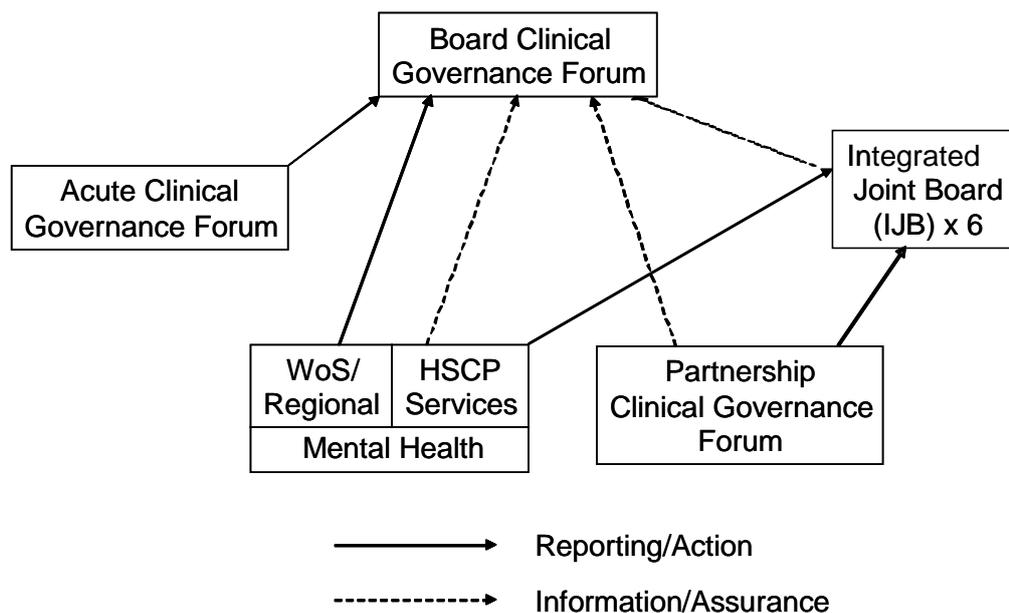
3.1 The scheme of delegation from the NHS Board to the HSCPs was approved in January 2015. It sets out the key functions of the board clinical governance forum and it's role in both directly NHS board managed services within acute care and selected regional mental health services together with its role of quality assurance for HSCP directly managed services.

3.2 In addition, the SPSP programme will continue to be developed on a board wide basis and the COs will be operationally responsible to ensure delivery. There are also a range of policies (for example the HIS adverse events policy) which will apply across all NHS healthcare services. The relevant extract from the scheme of delegation is set out below.

In respect of services for which the Board retains responsibility the Board Clinical Governance Forum is responsible for demonstrating compliance with statutory requirements in relation to clinical governance, authorising an accurate and honest annual clinical governance statement and responding to scrutiny and improvement reports by external bodies such as Healthcare Improvement Scotland. To achieve this, the Committee oversees a governance framework including a strategy, annual work programme, infrastructure of governance groups and an annual report. For services which the IJBs are responsible, they will be required to demonstrate through their partnership Clinical Governance committees/groups that they are compliant and provide demonstrable assurance to the Board Clinical Governance Forum. The Board wide patient safety programme needs to be operationally delivered by COs and scrutinised by IJBs with assurance provided to the Board Clinical Governance Committee.

3.3 It is therefore proposed that the basic structure of a board wide approach to acute, mental health and partnership governance is retained. However, the reporting arrangements and remit will change to reflect the new organisational arrangements both for HSCPs and acute care.

3.4 Both the acute clinical governance forum and the mental health services for which the board is directly accountable will have a **direct reporting** line to the board clinical governance forum. Other services will report directly to the HSCP governance structures with an assurance/information line to the board clinical governance forum. The diagram below sets out the proposed reporting and assurance arrangements.



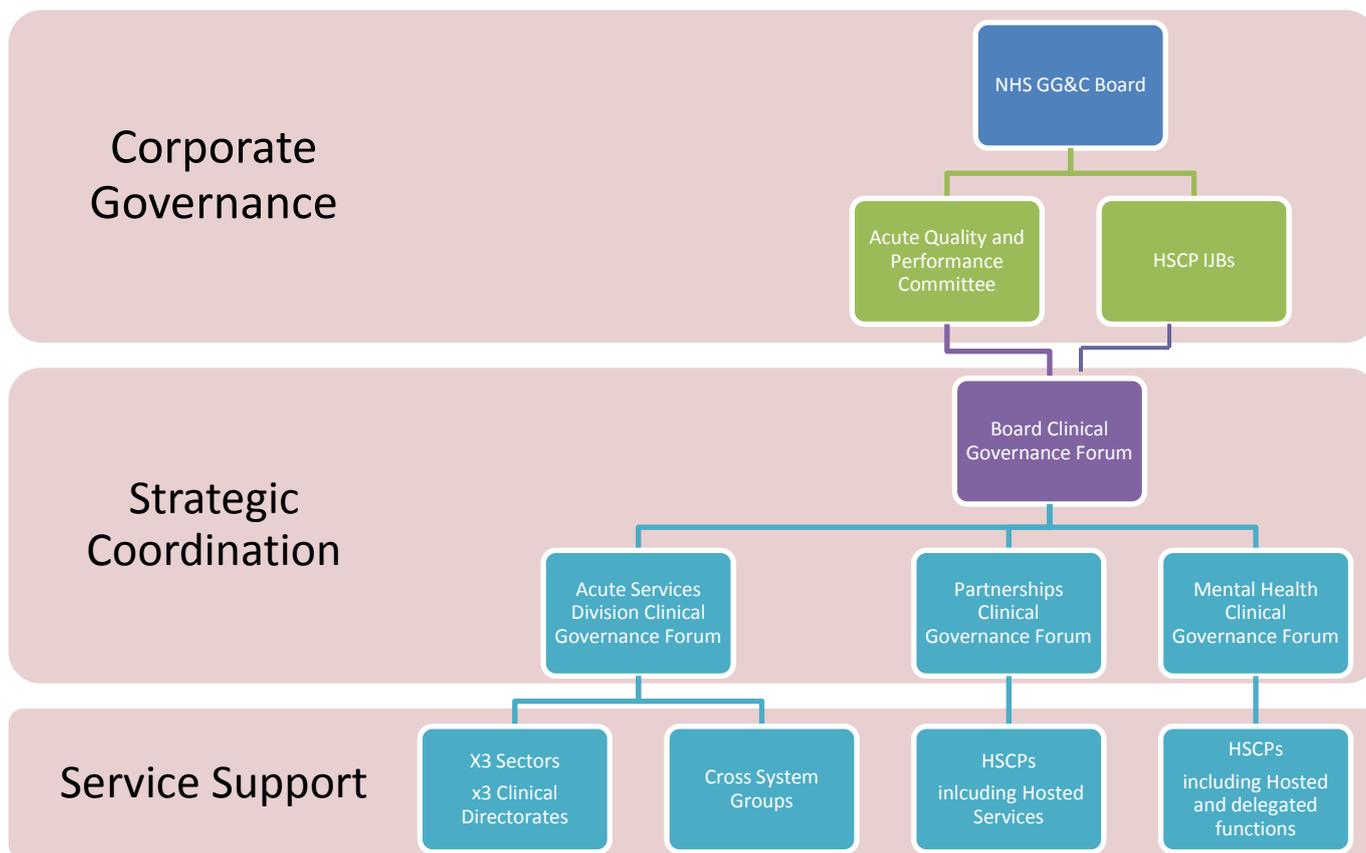
3.5 The remit of acute, mental health and partnership governance forums will be adapted to reflect the changing accountabilities and organisational arrangements.

- a. **The Partnership Clinical Governance Forum** is an NHS body which relates to the NHS GG&C Board Clinical Governance Forum, recognising that the local HSCP Clinical and Care Governance will involve both Health and Social Care. The existing Partnership Clinical Governance Forum will continue with a revised remit proposed as
 - i. Provide assurance to NHS GG&C Board about Clinical Governance arrangements within HSCPs
 - ii. Act as a central coordinating role for clinical governance in Partnerships across NHS GG&C, linking into NHS Board clinical governance structures and HSCPs clinical governance arrangements as required.
 - iii. Priority setting for clinical governance agenda linking into the NHS GG&C Board Clinical Governance Support Unit
 - iv. Provide cross-system coordination to the implementation of national improvement programmes e.g. Scottish Patient Safety Programme.
 - v. Ensure that learning is shared across all of NHS GG&C
 - vi. Review and approve clinical Policies / guidelines for use throughout the HSCPs within the Board Area
 - vii. Provide assurance to the NHS Board on quality and safety of care is maintained for those services which an HSCP hosts on behalf of other HSCPs or for directly managed service by the HSCPs, for example sexual health services
 - viii. Provide direct reports through the relevant arrangements to the board for the services the NHS Board is directly responsible for.
- b. Each HSCP will maintain a Clinical (or Care) Governance Forum with direct links to the Integrated Joint Board and the Partnership Clinical Governance Forum.
- c. The Board Clinical Governance Forum will establish advisory support to the Chief Officers Group as required and formalised links with each HSCP clinical governance forum

2. The **Mental Health Clinical Governance Forum** is an NHS body which relates to the NHS GG&C Board Clinical Governance Forum, recognising that the local HSCP Clinical and Care Governance will involve both Health and Social Care.
 - a. This group oversees governance issues in relation to NHS mental health services for adults, and through hosted arrangements with HSCPs for older adults, CAMHS, addictions and Tier 4 learning disability.
 - b. Mental Health Clinical Governance Forum will maintain a similar remit to that of the Partnership Clinical Governance Forum but applied to mental health services in respect of items 3a i-viii above.
 - c. In addition to support to HSCPs with direct, delegated or hosting responsibilities the Mental Health Clinical Governance Forum will also provide strategic coordination for the clinical governance relating to those mental services that remain direct NHS responsibility, notably forensic mental health services.
 - d. The HSCP partnerships will be required to develop local clinical governance arrangements for both mental health services which they directly managed as well as any services which are hosted by one of the HSCP on behalf of the other HSCPs.

3. The **Acute Services Division Clinical Governance Forum** will continue to provide the strategic coordination of clinical governance.
 - a. Each ASD Sector will establish a Sector Clinical Governance Forum with clear, regular reporting lines to the Director and links to the ASD CGF.
 - b. Each ASD Directorate will maintain a Directorate Clinical Governance Forum with clear, regular reporting lines to the Director and links to the ASD CG (Noting the current internal review underway in Women & Children Directorate).
 - c. The Sector Director, Chief of Medicine and Chief Nurse will establish a defined substructure of other CG Forums necessary to create engagement and support across all of its services
 - d. The sub-structure will reflect hospital and departmental general and clinical management structures (noting this is likely to reflect the sectoral management structures for medicine, surgery, theatres and older people).
 - e. The Sector Directors and CG leads will establish a defined substructure of other CG Forums necessary to create engagement and support across all of its services.
The value in retaining cross-system forums is well recognised but needs to be sustained in a way that reflects organisational decision making. The ASD CG Forum will retain responsibility for those existing cross system groups e.g. Thrombosis Committee. If no appropriate group exists short life working groups may be commissioned.
 - f. There will be other arrangements which enable specialities to link across GGC to review clinical outcome data and clinical quality e.g. MCNs, and these require further consideration.

3.6 These arrangements are set into a corporate, strategic and operational context in the diagram below. The Board Clinical Governance Forum will be reorganised to provide overall coordination and input to both the Acute Quality and Performance Committee (the expected replacement for the Q&P committee) and the HSCP overarching governance arrangements. The high level arrangements detailed in the section below which sets out corporate, strategic and operational.



Level A: Corporate Governance

- Ensures that NHS GG&C complies with its statutory duties, mandatory guidance, national standards and professional requirements.
- Assures the quality and safety of healthcare services delivered by NHS GG&C.
- Assures the suitability and effectiveness of clinical governance arrangements.

Level B Strategic Coordination

- Sets the key strategic aims for monitoring and improving clinical quality.
- Provides effective, active leadership for the Board's healthcare services in developing and maintaining the NHS GG&C clinical governance framework.
- Recognition, evaluation and escalation of critical concerns.
- Provides a key focal point for identifying and disseminating cross-organisational learning.
- Ensures integration and oversight of various CG Forums and groups advising on clinical policy/practice.

Level C: Service Support

- Provides effective support and delivery of healthcare services within a framework of clinical quality processes, procedures and controls.
- Enables key risks to clinical quality to be assessed and managed.
- Enables quality priorities to be defined and achieved.

4. Infrastructure to support clinical governance

4.1 The role of the clinical governance support unit will be retained as a central function to ensure that there is a critical mass of skilled staff to support clinical governance functions in the new organisational arrangements. This also ensures that there will be a consistent approach to implementing key clinical governance policies, ensuring the patient safety programmes are developed and implemented and providing advice and support on clinical effectiveness guidance.

4.2 However, the challenges highlighted the need for better clinical engagement in the national SPSP programme and patient centred care across primary, acute and mental health services. The board has been asked to effectively implement this programme. Progress has been slow and there is a need for both clinical strategic and local leadership to both develop and implement the programme.

4.3 In order to maximise the impact of senior clinical input, it is recommended that a coherent, system wide approach is taken with local ownership and distributed leadership. These will be funded by using a quota of recycled SPA time as set out in a recent paper. The **Clinical quality network** will be housed in the Clinical Governance Unit and will be described in more detail later. However clinicians will work at 3 levels:

- **Hub Clinical Lead** - safety fellows with high levels of experience, they will be based locally and in the CGU working with the senior team. They will manage the programme across all aspects of health care with high levels of expertise.
- **Spoke Clinician** - these clinicians will be based in their local HSCP/hospital/directorate and **report to the relevant local** clinical manager but will link with the hub team and front line staff and work with local clinical risk managers and clinical teams to implement patients' safety/quality programmes.
- **Rim** - these will be front line clinicians based in areas of particular high risk who will implement policy and feedback on what needs to change/adapt.

4.4 The quality of NHS services should be routinely reviewed to assess standards and understand how quality is improving through time. The creation of stronger links between Clinical Governance and Healthcare Information is seen as crucial developing and tracking a more extensive range of clinical quality indicators, identify areas for in-depth analysis, design more effective data capture to help those in direct care teams and improve the section and presentation of clinical quality indicators.

4.5 The CGSU will also develop with the chief operating officer, the Board Medical and Nurse Director and Director of HIT an assurance function, supported by clinical outcome data to support clinical teams to improve the quality of care, detect variation, service failures and areas for improvement at an early warning stage.

5. Transition and key recommendations

5.1 The process of transition to the planned organisational arrangements is underway. This paper acknowledges ongoing development will occur but to mitigate transition risks there are a number of key recommendations as follows:

1. The basic structure of the strategic clinical governance forums will be retained.
2. The reporting arrangements and remit of these forums will be developed to reflect the new organisational arrangements, for both HSCPs and acute care.
3. The role of the clinical governance support unit will be retained as a central function
4. The Clinical Quality Network will be developed to enhance expertise supporting key improvement programmes
5. A more extensive range of clinical quality indicators will be developed to enhance assurance

6. The **Board Clinical Governance Forum** will continue to provide the strategic coordination of clinical governance. Key functions are set out below.
 - a. Develop and publish a revised Clinical Governance Framework as essential policy and guidance to services.
 - b. Evaluate local arrangements, providing advice on any required developments and escalating any issues of either major or persistent concern.
 - c. Strengthen processes for cross-system monitoring and shared learning.
 - d. Create a process for publishing a quarterly report to the NHs Board on
 - i. The prevailing clinical governance arrangements
 - ii. Progress against clinical quality priorities
 - iii. The emergence of clinical risks and new priorities
7. The HSCP Chief Officers, ASD Chief Officer, ASD Directors, will
 - a. Ensure the maintenance of appropriate and effective clinical governance arrangements
 - b. Confirm the processes for the early identification and escalation of risks to the quality of clinical care
 - c. Ensure there is a local supporting infrastructure, including the designation of local Clinical Quality Improvement Leads.
 - d. Ensure there is a scheme of local review and reporting that supports management and assurance, and can be consolidated into an annual clinical governance report