Appendix 3

North Cumbria University Hospitals NHS
NHS Trust

REVIEW OF CLINICAL GOVERNANCE FINAL VERSION JANUARY 2011

DOCUMENT CONTROL:

Version 1 09/12/2010	First draft for review with Medical Director and Associate Medical Directors.
Version 2 13/12/2010	Second draft for review by Governance and Quality Committee, Clinical Standards Sub Group and LINks.
Version 3 20/12/2010	Third Draft incorporating comments from Chairman of Cumbria LINks.
Version 4 21/12/2010	Forth draft incorporating comments from Chief Executive, Deputy Chief Executive, Acting QIPP Director and Head of Governance and Quality.
Version 5 21/12/2010	Fifth draft for further comments from clinical divisions, key stakeholders and Executive Management Team Colleagues.
Version 6 05/01/2011	Final version for Trust Board Approval on 11/01/2011

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1. EXECUTIVE SUMMARY

The purpose of this document is to outline how the review of clinical governance within North Cumbria University Hospitals NHS Trust will be taken forward, following the recommendation outlined in the Breast Screening Incident report, which was published in November 2010.

The target audiences for this report include:

- Patients
- Staff
- Public
- Local Stakeholders (i.e. LINks and Overview and Scrutiny Committee)
- GP Clinical Leads
- Cumbria Primary Care Trust

This document describes the background to clinical governance as well as specific terms of reference which have been defined to ensure a structured approach is applied to reviewing clinical governance across the organisation. This will ensure that any improvements or lessons to be learned can be taken forward and add value to the development of clinical governance in the Trust.

In summary the specific objectives for these terms of reference include:

- To examine compliance and evidence of meeting CQC Essential Standards of Safety and Quality and how this information is shared with stakeholders.
- Independent assessment of the robustness of the Trust's Clinical Audit function.
- Independent assessment of the provision and monitoring of mandatory training across nursing, medical and non clinical staff.
- Independent assessment of the robustness of the Trust's system for the recording and monitoring of appraisals for all staff.
- Independent assessment of the robustness of the Trust's system for recording and monitoring compliance with NICE clinical guidance, including the reviewing of clinical guidelines based on best practice.
- To determine whether the Trust's strategy for Governance, Risk and Quality is fully embedded across all wards and departments in the Trust.
- To determine whether the current governance support structure is fit for purpose to support the implementation and development of effective clinical governance across the Trust.
- To determine whether all specialties have in place robust clinical audit and review systems, including external peer review and benchmarking to ensure effective clinical governance arrangements are in place for all clinical specialties.

2. INTRODUCTION

In July 2010, the Trust's Breast Screening Service was suspended following an interim visit by a radiologist from the regional Quality Assurance Team. This resulted in a serious untoward incident being declared and a full investigation being launched by Cumbria Primary Care Trust and the Trust.

In October 2010 the report into the Breast Screening Incident was published by the Primary Care Trust which set out specific recommendations for implementation.

One of the recommendations stated that:

- A *review of clinical governance procedures should be carried out by North Cumbria University Hospitals Trust in other services provided by the hospitals trust to ensure proper processes are in place. The results of this review should be presented to the NCUHT and NHS Cumbria Trust Boards.*

It is important to outline that whilst this recommendation relates fundamentally to reviewing the systems and processes we have to ensure the standards of care we deliver are safe, this is a precautionary measure, to ensure we implement this recommendation with the correct rigour and within reasonable timeframes.

To progress with taking forward the review of clinical governance it has been agreed by the Trust Board that specific terms of reference should be established to define the key areas to be reviewed as well as being explicit on the timescale for completion and key leads involved.

3. BACKGROUND & CONTEXT

Clinical Governance has evolved and developed across the NHS. The first White Paper from the Labour Government *'The new NHS Modern, Dependable (1997)'* set out a clear priority for modernising the NHS through quality improvement.

In 1998, *'A First Class Service: Quality in the new NHS'* was published which set out how quality should be at the heart of the day to day delivery of care to patients in the NHS. It described the setting, delivery and monitoring of quality standards across the NHS.

It also set out a clear definition of clinical governance:

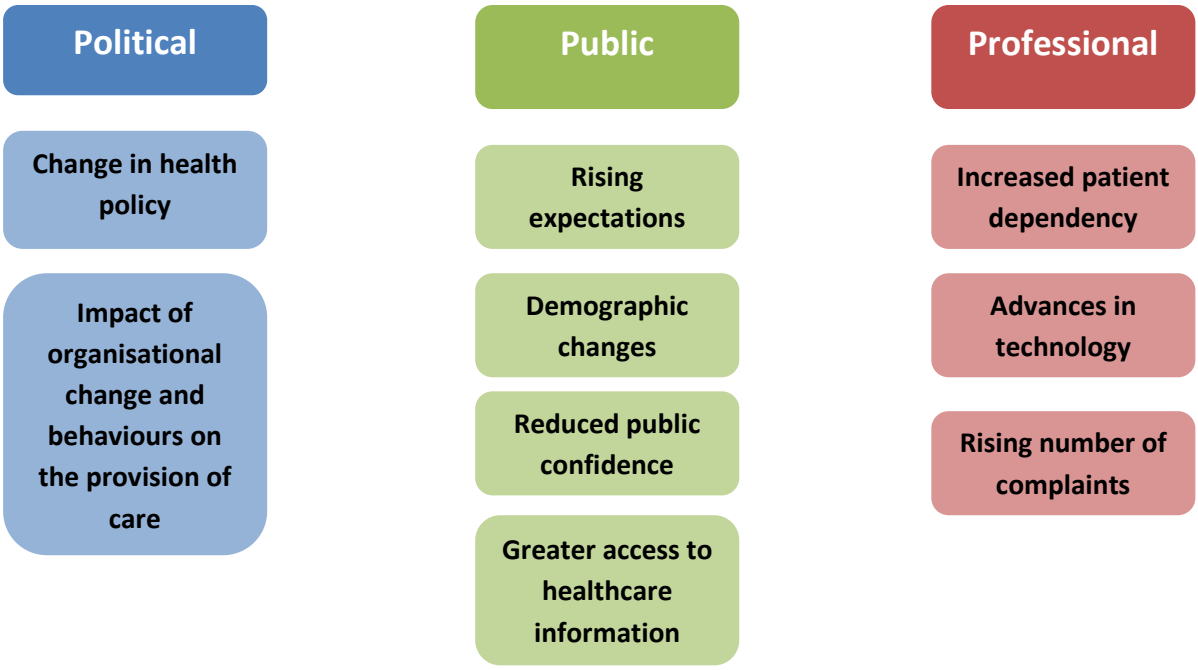
'*Clinical governance can be defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (A First Class Service: 1998).*

In essence clinical governance was born out of the need for real accountability for the safe delivery of health services. It is important to highlight as part of the context that this was also due to the publics and professionals' perception of systemic failings within the NHS, where the confidence in the safety and quality of care had been both questioned and compromised.

In addition to NHS organisations being held to account, various regulatory bodies have also been established to oversee the implementation of safe care across the NHS, notably the Commission for Health Improvement, Healthcare Commission and the current Care Quality Commission.

Three key drivers have also affected the development of clinical governance in the NHS, which McSherry and Pearce (2007) describe as:

Figure 1: Political, Public and Professional Drivers (McSherry and Pearce 2007)



The political and professional aspects can be further built on in the current climate with the economic challenges facing the whole of the NHS as well as increased professional regulation such as the impending revalidation for medical staff.

The development of patient, public and carer involvement is also important to note in the context of how clinical governance has developed and the legitimate bodies and functions which have been set up and evolved as a result. These include the publication of the patient's charter in 1992, the introduction of PALS, the local patient and public involvement forums and the current Local Involvement Networks. The publication of the NHS Constitution also highlighted the specific rights that patients, public and staff working in the NHS should have.

The Trust Board have defined key stakeholder groups referred to in these terms of reference, and have set out specific intended outcomes for the various stakeholder groups.

Table 1: Key Stakeholders and intended outcomes

Patients and Public	Provide our patients and public with reassurance that the systems and processes we have in place ensure that we provide, safe quality care within a robust governance framework that allows the Trust to make any improvements necessary from this review.
Trust Staff	Ensure we involve all staff in developing our clinical governance arrangements, including making any improvements necessary on the standards of care we provide or the systems and processes we have in place to ensure the safe delivery of care. To support our staff in ensuring their awareness of their responsibilities within the context of clinical governance.
GP Clinical Leads	Provide our future GP commissioners with assurance that this recommendation as set out in the Breast Screening Service report has been implemented robustly, with the sharing of any lessons learned or areas for improvement. To ensure that all of our services are provided within the context of a resilient and over arching governance framework.
Cumbria PCT	Provide our commissioners with assurance that this recommendation as set out in the Breast Screening Service report has been implemented robustly, with the sharing of any lessons learned or areas for improvement.
Overview and Scrutiny Committee	Provides the Cumbria Health and Wellbeing Scrutiny Committee with assurance that this recommendation has been taken forward thoroughly across the organisation.
Local Involvement Network	Provides the Local Involvement Network with assurance that this recommendation has been taken forward thoroughly across the organisation and has involved them in any lessons or improvements which may need to be implemented.
Care Quality Commission	Provides the regulatory body with reassurance that the standards of care provided in our organisation meet those set out by the CQC.
Local MPs	Provides our local MPs with reassurance on the standard of care provided at the Trust's two hospital sites.

4. GUIDING PRINCIPLES

It is important that guiding principles for this review are agreed and understood by staff, stakeholders and patient representatives.

4.1 Transparency and independence

It is important to ensure this review is transparent in terms of what the review is aiming to achieve, how this achievement will be measured and reported and how this will be taken forward. This is to ensure the appropriate roles and individuals in the organisation are involved as well as applying the correct level of independence to avoid any potential organisational influence.

Specific terms of reference for this review have been developed and shared with stakeholders to ensure the outcomes can be openly communicated. As part of the terms of reference, independent assurance on specific aspects of the review will also be included, for example reviewing core aspects of governance such as mandatory training and appraisal. By ensuring transparency we will demonstrate the organisations willingness to embrace and deliver change where required.

4.2 Participation

It should be recognised that clinical governance affects and involves all stakeholders. It is also pertinent to recognise the important and legitimate role that stakeholders and partners have in contributing to the overall governance framework of the organisation. Accordingly, participation from all staff and stakeholders will be an important component of the terms of reference for this review. By ensuring appropriate participation we will add ownership and legitimacy to the outcomes of the review.

4.3 Learning and improving

Clinical governance is also about ensuring organisations continuously improve and that lessons are learned for the future. The outcome of this review will provide clarity on aspects of the Trust's clinical governance arrangements that require improving, whether at specific department, specialty or Trust level. In addition it is also important to learn from successes and mistakes and ensure this is shared across the organisation. This review will do this and also provide objective measures and feedback loops to ensure that lessons learned are actioned into daily routines of quality care delivery.

5. SCOPE & OBJECTIVES OF THE TERMS OF REFERENCE

Clinical governance is ever-present in the day to day provision of healthcare to patients. To ensure this review adds value to the organisation in identifying any areas which require improvement the scope of this review has been separated into five specific sections:

- Compliance and evidence of meeting CQC Essential Standards of Safety and Quality
- Internal Audit Review of specific aspects of clinical governance
- Governance in practice
- Governance Support Structure
- Framework to support small / single handed Consultant Teams

The rationale for defining the above specific sections has been derived from the recognition by the Medical Director and Director of Nursing, Quality and Governance that the above areas are central to the effectiveness of clinical governance across the organisation.

Each of the sections will be described in further detail below outlining the specific terms of reference. In addition a specific summary outlining what will be reviewed, how this will be undertaken, reporting framework and timescale for completion is also attached at appendix 1.

5.1 Section 1 – Compliance and Evidence of meeting CQC Essential Standards of Safety and Quality

The CQC is the key regulatory body for care provided by the NHS, local authorities, private companies and voluntary organisations. They aim to make sure better care is provided for everyone - in hospitals, primary care, care homes, people's own homes and ambulance services. In March 2010 the Trust was fully registered with the CQC with no conditions.

The CQC has set out 'Essential standards of quality and safety' consisting of 28 Regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. For each Regulation, there is an associated outcome – the experiences we expect people to have as a result of the care they receive and 'Prompts' which draw attention to key compliance issues.

The CQC has an ongoing process for checking our compliance with the essential standards and focus on the 16 Regulations that mostly relate to the quality and safety of care (attached at appendix 2 for information). The other 12 Regulations relate to more routine day-to-day management of a service that are monitored periodically or where concerns are raised about any specific Regulation (attached at appendix 3 for information).

From 1 October 2010, every health and adult social care service in England became legally responsible meeting the 'Essential standards of quality and safety'. Key points from the Legislation have been set out by the CQC for the public as follows:

1. You can expect to be involved and told what's happening at every stage of your care

- You will always be involved in discussions about your care and treatment, and your privacy and dignity will be respected by all staff.
- You will be given opportunities, encouragement and support to promote your independence.
- You will be able to agree or reject any type of examination, care, treatment or support before you receive it.

2. You can expect care, treatment and support that meets your needs

- Your personal needs will be assessed to make sure you get care that is safe and supports your rights.
- You will get the food and drink you need to meet your dietary needs.
- You will get safe and co-ordinated care where more than one care provider is involved or if you are moved between services.

3. You can expect to be safe

- You will be protected from abuse or the risk of abuse, and staff will respect your human rights.
- You will be cared for in a clean environment where you are protected from infection.
- You will get the medicines you need, when you need them, and in a safe way.
- You will be cared for in a safe and accessible place that will help you as you recover.
- You will not be harmed by unsafe or unsuitable equipment.

4. You can expect to be cared for by qualified staff

- Your health and welfare needs are met by staff who are properly qualified.
- There will always be enough members of staff available to keep you safe and meet your health and welfare needs.
- You will be looked after by staff who are well managed and have the chance to develop and improve their skills.

5. You can expect your care provider to constantly check the quality of its services

- Your care provider will continuously monitor the quality of its services to make sure you are safe.
- If you or someone acting on your behalf makes a complaint, you will be listened to and it will be acted upon properly.
- Your personal records, including medical records, will be accurate and kept safe and confidential.

Key objective:

- **To examine compliance and evidence of meeting CQC Essential Standards of Safety and Quality and how this information is shared with stakeholders.**

5.2 Section 2 – Internal Audit Review

The Trust has an internal audit service provided by Cumbria Internal Audit and Counter Fraud Consortium. This is an important component of the Trust's governance framework in that it provides an independent review on key activities across the organisation, both clinical and non-clinical. It has been agreed that an independent review is undertaken by internal audit into areas that the Medical Director and Director of Nursing, Quality and Governance feel are necessary to provide a current understanding on how these key aspects of clinical governance are operating across the Trust at this present time.

These areas include:

- Clinical audit
- Mandatory Training (all staff)

- Appraisal (all staff)
- Implementation of NICE guidance and clinical standards

In addition, internal audit will also be conducting their annual review of governance across the organisation in order to provide their head of internal audit opinion at the end of the financial year; this will include a review of the Trust's governance and risk management arrangements.

Key objectives:

- **Independent assessment of the robustness of the Trust's Clinical Audit function.**
- **Independent assessment of the provision and monitoring of mandatory training across nursing, medical and non clinical staff.**
- **Independent assessment of the robustness of the Trust's system for the recording and monitoring of appraisals for all staff.**
- **Independent assessment of the robustness of the Trust's system for recording and monitoring compliance with NICE clinical guidance, including the reviewing of clinical guidelines based on best practice.**

5.3 Section 3 – Governance in practice

The development of the divisional management structure has continued to evolve during the last 12-18 months with the introduction of key roles such as the Governance Facilitators.

In addition to this the Trust has developed a new governance, risk and quality strategy which has been approved by the Trust Board and continues to be embedded across the organisation. This strategy defines 'core pillars' of governance which are illustrated below:

Figure 2: Core Pillars of Governance

The Trust's new strategy supports the principles set out in the Integrated Governance Handbook, 2006, in that corporate and clinical governance should be embedded in organisations to ensure a robust overarching framework for governance exists across NHS organisations and supports financial, clinical, and technological or workforce issues in relation to governance.

It is important as part of the review of clinical governance to understand how embedded the new arrangements are and to review 'governance in practice' to ensure robust frameworks exist within individual wards and departments for the management of clinical governance.

Key objective:

- **Is the Trust's strategy for Governance, Risk and Quality fully embedded across all wards and departments in the Trust.**

5.4 Section 4 – Governance Structure

During the last two years the Trust has invested in certain aspects of the Trust's support structure for governance, which is managed and lead by the Director of Nursing, Quality and Governance. It has been agreed that a review of the current structure will be undertaken jointly by the Medical Director and Director of Nursing, Quality and Governance to ensure this is fit for the future.

This will include the management of the medical director's office and the importance education and training has on the governance of the organisation.

Key objective:

- **Is the current governance support structure fit for purpose to support the implementation and development of effective clinical governance across the Trust.**

5.5 Section 5 – Framework to support small / single handed Consultant Teams

It is recognised that a key area organisations should continuously review and ensure robust governance systems exist are those which relate to small departments and single handed consultant teams. The Trust has reviewed this as an important component of reviewing clinical governance and has therefore included this as a specific section of the terms of reference.

It is important to outline that all departments and consultant teams within the Trust are subject to the appropriate benchmarking and clinical practice reviews, for example national audits and royal college guidance.

Key objective:

- **Do all specialties have in place robust clinical audit and review systems, including external peer review and benchmarking to ensure effective clinical governance arrangements are in place for all clinical specialties.**

6. GOVERNANCE AND REPORTING

This document and specific objectives for the terms of reference have been developed at the request of the Trust Board of North Cumbria University Hospitals NHS Trust as part of responding to the recommendations made in the Breast Screening Incident Report.

The Governance and Quality Committee and Clinical Standards Sub Group have reviewed the terms of reference in December 2010, in order for these to be ratified by the Trust Board in January 2011. It should be noted that some of the areas outlined in the terms of reference have already started to be implemented and are being overseen by the Executive Management Team.

It is important to note that key stakeholders have been invited to comment on the terms of reference and seek any points of clarification before these are ratified by the Trust Board.

It is proposed that the Executive Management Team will review on a weekly basis, by exception, progress against the delivery of these terms of reference as well as the review of any immediate issues which require action as part of the implementation of the various streams of work.

It is also important to outline that the Trust's Management Committee will also be kept appraised of progress against the delivery of these terms of reference given the importance they have across each of the clinical Divisions.

The reporting sections which have been outlined in each of the above sections include references to both the Governance and Quality Committee and Audit Committee. The reason for this is not to introduce duplication, but to ensure the Governance and Quality Committee are involved on the outcomes of the various pieces of work, whilst at the same time ensuring some independence is applied by the Audit Committee reviewing key aspects and outcomes from the various sections of work.

7. LEADS & TIMESCALES FOR COMPLETION

The five sections to these terms of reference set out specific dates for completion (appendix 1). In relation to the overall terms of reference, these will be completed and formally reported to the Trust Board in June 2011.

The outputs from this review in terms of findings will be included in a detailed action plan to ensure any areas of improvement or non compliance are taken forward and implemented promptly.

The Medical Director and Director of Nursing, Quality and Governance are joint lead Directors for the implementation of these terms of reference and will be supported by the Company Secretary on behalf of the Trust Board.

8. RECOMMENDATION

That the Board approves the scope and key objectives for reviewing clinical governance across the Trust, following the recommendation included in the Breast Screening Incident Report, published in November 2010.

APPENDIX 1

SPECIFIC AREAS FOR REVIEW IN SECTION 1 – CQC COMPLIANCE:

a) Does the Trust have robust evidence in place to ensure the 'Essential standards of quality and safety' are achieved across the Trust.
b) Can the Trust evidence that a robust monitoring system is in place to ensure the requirements and outcomes for each of the Regulations set out in Appendix 1 are achieved across the Trust.
c) Does the Trust share compliance data and evidence with their local stakeholders, including LINks to assure its members that the Trust is fully compliant against these standards.

METHODOLOGY:

In order to demonstrate compliance with the 16 outcomes we will:

- Demonstrate that we have reviewed existing evidence and monitoring systems to confirm the robustness of the current system and supporting evidence and identify any areas that require improvement or further evidence.
- Undertake a 'spot review' of 3 specific Regulations which will be determined and undertaken with stakeholder input, particularly Cumbria LINk.
- Ensure that awareness of the 'Essential standards of quality and safety' is reviewed across all clinical wards and departments through to the Divisional Management Boards and ultimately Trust Board.

KEY LEADS:

Head of Governance and Quality, Compliance Manager, Governance Facilitators, Heads of Nursing, Clinical Directors

TIMEFRAME:

- Commencement date: February 2011
- Completion date: May 2011

REPORTING

- Detail reviewed by Divisional Management Boards
- Reviewed by Governance Committee
- Reviewed by Audit Committee
- Reported to Trust Board
- Reported to Cumbria LINk

SPECIFIC AREAS FOR REVIEW IN SECTION 2 – CLINICAL AUDIT

a) Does the Trust have in place robust arrangements for the provision of clinical audit, including the requirements of Health Quality Improvement Partnership (HQIP).
b) How does the Trust's internal clinical audit function ensure national and local audits are implemented and any outcomes are taken forward in relation to improvements to clinical practice.
c) How does the Trust monitor and review the outcomes from clinical audit.
d) How does the Trust monitor the undertaking of clinical audit by individual clinical practitioners.

METHODOLOGY:

In order to address the above:

- A review of the current policies and procedures for the practice of clinical audit and how this is rolled out across the organisation.
- Benchmark of the organisations current clinical audit standards against HQIP and other relevant guidance.
- Review of the quality / outputs from the clinical audit department.

KEY LEADS

Review lead by Internal Audit, Medical Director, Medical Directors Office Manager and Clinical Audit Manager

TIMEFRAME:

- Commencement date: Already in progress
- Completion date: December 2010

REPORTING

- Reviewed and reported to Audit Committee
- Reviewed by Governance and Quality Committee
- Reported to the Trust Board

SPECIFIC AREAS FOR REVIEW IN SECTION 2 – MANDATORY TRAINING

a) Does the Trust have in place an agreed matrix for the provision of mandatory training across nursing, medical and non clinical staff.
b) Do the Trust's policies provide clarity between statutory and mandatory training?
c) Does the Trust have robust policies and procedures which define how (a) is monitored and reviewed.
d) Are the mandatory training programmes accessible and flexible to meet the needs of all staff, including time to release staff to attend training.
e) Does the Trust have in place robust recording systems for all staff to record their mandatory training and identify update training.
f) Does the Trust have in place robust systems to ensure the necessary training / competency records are in place and checked for all temporary or locum staff in all clinical specialties.
g) Does the Trust's arrangements for mandatory training support the provisions set out in the CQC regulation for staff training and competency.

METHODOLOGY:

In order to address the above:

- A review of the current supporting policies and procedures and supporting recording systems.
- Benchmark against best practice (CQC regulation).
- Review of the current mandatory and statutory training programmes in terms of accessibility.
- A baseline of mandatory training for all staff groups will also be undertaken to determine current uptake levels

KEY LEADS:

Review lead by Internal Audit, Associate Medical Director – Medical Education, Head of Education and Training, Business Manager – Education and Training, Divisional General Managers, HR Business Partners

TIMEFRAME:

- Commencement date internal audit: January 2011
- Completion date internal audit: March 2011
- Completion date for baseline assessment for all staff: February 2011

REPORTING:

- Reviewed and reported to Audit Committee
- Reviewed by Governance and Quality Committee
- Reported to the Trust Board

SPECIFIC AREAS FOR REVIEW IN SECTION 2 – APPRAISAL

a) Does the Trust have in place a robust system for the recording and monitoring of appraisals for all staff.
b) Do the Trust's policies for appraisal and CPD set out the specific requirements for all staff in relation to the responsibilities and accountabilities for undertaking and monitoring appraisal, including medical staff appraisal.
c) Does the Trust's appraisal system contribute to the development of our staff.
d) Does the Trust have in place adequate training for staff who undertake appraisals.

METHODOLOGY:

In order to address the above:

- A review of the current supporting policies and procedures and supporting recording systems.
- A review of progress against the organisations plans for improving medical staff appraisal in preparation for the introduction of medical revalidation.
- Benchmark against best practice including CQC regulation and guidance from professional bodies such as RCN and BMA.

KEY LEADS:

Review lead by Internal Audit, Deputy Medical Director (revalidation), Associate Medical Director – Medical Education, Head of Education and Training, Business Manager – Education and Training, Divisional General Managers, HR Business Partners

TIMEFRAME:

- Commencement date: In progress
- Completion date: February 2011

REPORTING:

- Reviewed and reported to Audit Committee
- Reviewed by Governance and Quality Committee
- Reported to the Trust Board

SPECIFIC AREAS FOR REVIEW IN SECTION 2 – IMPLEMENTATION OF NICE GUIDANCE AND CLINICAL STANDARDS

a) Does the Trust have in place a robust system for the recording and monitoring of NICE guidance issued to the Trust.
b) Does the Trust have in place a robust system to review clinical guidelines and protocols to ensure they are subject to regular review.
c) Does the Trust have in place a system to respond to national guidelines issued to ensure any relevant gap analyses are undertaken to benchmark against current clinical practice.
d) Does the Trust have in place a robust system to monitor the clinical standards across the organisation through the use of CHKS.

METHODOLOGY:

In order to address the above:

- Current electronic and supporting paper based systems will be reviewed.
- System for responding to national alerts will be reviewed.
- Implementation and skills for reviewing the Trust's principle tool for monitoring clinical standards across the divisions will be reviewed (CHKS).

KEY LEADS:

Review will be led by Internal Audit, Head of Governance and Quality, Clinical Effectiveness Facilitator, Divisional General Managers and Business Managers, Governance Facilitators, Associate Medical Directors

TIMEFRAME:

- Commencement date: In progress
- Completion date: March 2011

REPORTING:

- Reviewed and reported to Audit Committee
- Reviewed by Governance and Quality Committee
- Reported to the Trust Board

SPECIFIC AREAS FOR REVIEW IN SECTION 3 – GOVERNANCE IN PRACTICE

a) Is the new strategy and 'core pillars' framework accessible to all staff and key clinical leaders (i.e. Heads of Nursing & Midwifery, Clinical Directors and Clinical Leads).
b) Do all staff understand the core components of clinical governance and how this is managed across the Trust.
c) Does the Trust's strategy ensure a 'ward to board' approach exists for governance, quality and risk.

METHODOLOGY:

In order to address the above:

- This review will be led by the Director of Nursing, Quality and Governance, Medical Director and Associate Medical Directors.
- The clinical governance arrangements and accountabilities from 'ward to board' will be reviewed across all clinical areas, including the ward and departmental arrangements for discussing and reviewing clinical governance.
- A survey of key clinical staff (i.e. Heads of Nursing & Midwifery, Clinical Directors and Clinical Leads) and roles will be undertaken on the organisations core pillars and clinical governance framework.
- The information included in the Trust's induction and corporate mandatory training will be reviewed against the framework set out in the new strategy.

KEY LEADS:

Medical Director, Associate Medical Directors, Director of Nursing, Quality and Governance, Deputy Directors of Nursing

TIMEFRAME:

- Commencement date: January 2011
- Completion date: March 2011

REPORTING:

- Reviewed and reported to Audit Committee
- Reviewed by Governance and Quality Committee
- Reported to the Trust Board

SPECIFIC AREAS FOR REVIEW IN SECTION 4 – GOVERNANCE STRUCTURE

a) Does the current governance structure support the core functions of clinical governance across the organisation from both a nursing and medical perspective.
b) Does the current structure need to include other functions within the organisation to provide clarity on the clear link with clinical governance across the organisation.
c) Does the current structure provide the correct resource and roles to support the effective management of governance across the Trust.
d) Does the current structure support the joint functions of the Director of Nursing, Quality and Governance and Medical Director in their respective accountable roles for clinical governance.

METHODOLOGY:

In order to address the above:

- The roles, functions and accountabilities of key functions in the governance structure will be reviewed.
- HR will be involved to ensure any proposed changes are managed through the organisational change policies and procedures.

KEY LEADS:

Director of Nursing, Quality and Governance, Medical Director, Director of HR and OD, Company Secretary , Head of Governance and Quality

TIMEFRAME:

- Commencement date: December 2010
- Completion date: March 2011

REPORTING:

- Reported to EMT
- Reported to Trust Board (as part of final report)

SPECIFIC AREAS FOR REVIEW IN SECTION 5 – FRAMEWORK TO SUPPORT SMALL / SINGLE HANDED CONSULTANT TEAMS

a) Do all specialties have in place and take part in national clinical audits and benchmarking.
b) Do all specialties have in place robust and regular peer reviews on clinical outcomes, including mortality and morbidity information, which also ensures adequate external peer review and benchmarking.
c) Do the clinical specialties have agreed set clinical standards that are measured and reviewed at consultant level.
d) Do the Divisions have in place a robust system to monitor the outcome of peer or clinical reviews in terms of recommendations and follow up at multidisciplinary team level, including robust MDTs.
e) Are single handed / small consultant teams fully part of Divisional Board Business, are they adequately represented and do they have access to the appropriate peer support.

METHODOLOGY:

In order to address the above:

- The national guidance and benchmarks to ensure regular monitoring against agreed best practice standards of care within specific specialties will be reviewed in terms of the organisations overall compliance.
- The peer review process for clinical outcomes will be reviewed.
- The structure and reporting of outcomes from Mortality and Morbidity reviews will also be included.
- The individual consultant information on CHKS will also be reviewed in terms of how this is used to contribute to the levels of understanding of variations amongst individual consultant practice.

KEY LEADS:

Head of Governance and Quality, Governance Facilitators, Clinical Directors, Associate Medical Directors, Divisional General Managers, Medical Director

TIMEFRAME:

- Commencement date: January 2011
- Completion date: May 2011

REPORTING:

- Reporting directly to Trust Board

APPENDIX 2

Regulation*	Outcome	Title and summary of outcome
9	**4**	**Care and welfare of people who use services** People experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.
10	**16**	**Assessing and monitoring the quality of service provision** People benefit from safe, quality care because effective decisions are made and because of the management of risks to people's health, welfare and safety.
11	**7**	**Safeguarding people who use services from abuse** People are safeguarded from abuse, or the risk of abuse, and their human rights are respected and upheld.
12	**8**	**Cleanliness and infection control** People experience care in a clean environment, and are protected from acquiring infections.
13	**9**	**Management of medicines** People have their medicines when they need them, and in a safe way. People are given information about their medicines.
14	**5**	**Meeting nutritional needs** People are encouraged and supported to have sufficient food and drink that is nutritional and balanced, and a choice of food and drink to meet their different needs.
15	**10**	**Safety and suitability of premises** People receive care in, work in or visit safe surroundings that promote their wellbeing.
16	**11**	**Safety, availability and suitability of equipment** Where equipment is used, it is safe, available, comfortable and suitable for people's needs.

17	**1**	**Respecting and involving people who use services** People understand the care and treatment choices available to them. They can express their views and are involved in making decisions about their care. They have their privacy, dignity and independence respected, and have their views and experiences taken into account in the way in which the service is delivered.
18	**2**	**Consent to care and treatment** People give consent to their care and treatment, and understand and know how to change decisions about things that have been agreed previously.
19	**17**	**Complaints** People and those acting on their behalf have their comments and complaints listened to and acted on effectively, and know that they will not be discriminated against for making a complaint.
20	**21**	**Records** People's personal records are accurate, fit for purpose, held securely and remain confidential. The same applies to other records that are needed to protect their safety and wellbeing.
21	**12**	**Requirements relating to workers** People are kept safe, and their health and welfare needs are met, by staff who are fit for the job and have the right qualifications, skills and experience.
22	**13**	**Staffing** People are kept safe, and their health and welfare needs are met, because there are sufficient numbers of the right staff.
23	**14**	**Supporting workers** People are kept safe, and their health and welfare needs are met, because staff are competent to carry out their work and are properly trained, supervised and appraised.
24	**6**	**Cooperating with other providers** People receive safe and coordinated care when they move between providers or receive care from more than one provider.

* Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

APPENDIX 3

Regulation	Outcome	Title and summary of outcome
4*	**22**	**Requirements where the service provider is an individual or partnership** People have their needs met because services are provided by people who are of good character, fit for their role, and have the necessary qualifications, skills and experience.
5*	**23**	**Requirement where the service provider is a body other than a partnership** People have their needs met because services are managed by people who are of good character, fit for their role, and have the necessary qualifications, skills and experience.
6*	**24**	**Requirements relating to registered managers** People have their needs met because services have registered managers who are of good character, fit for their role, and have the necessary qualifications, skills and experience.
7*	**25**	**Registered person: training** People have their needs met because services are led by a competent person who undertakes the appropriate training.
12**	**15**	**Statement of purpose** People know that the Care Quality Commission is kept informed of the services being provided.
13**	**26**	**Financial position** People can be confident that the provider has the financial resources needed to provide safe and appropriate services.
14**	**27**	**Notifications – notice of absence** People can be confident that, if the person in charge of the service is away, it will continue to be properly managed.
15**	**28**	**Notifications – notice of changes** People can be confident that, if there are changes to the service, its quality and safety will not be affected.

16**	**18**	**Notification of death of a person who uses services** People can be confident that deaths of people who use services are reported to CQC so that, if necessary, action can be taken.
17**	**19**	**Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983** People who are detained under the Mental Health Act can be confident that important events that affect their health, welfare and safety are reported to CQC so that, if necessary, action can be taken.
18**	**20**	**Notification of other incidents** People who use services can be confident that important events that affect their health, welfare and safety are reported to CQC so that, if necessary, action can be taken.
19**	**3**	**Fees** People who pay for services know how much they are expected to pay, when and how, and what service they will get for the amount paid.

* Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

** Regulation of the Care Quality Commission (Registration) Regulations 2009