

**FINAL REPORT ON THE
REVIEW OF CLINICAL
GOVERNANCE
JULY 2011**

1. 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 NHS Cumbria and the Trust.

In October 2010 the report into the Breast Screening Incident was published by NHS Cumbria, which set out specific recommendations for implementation.

One of the recommendations in the report 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.*

During December 2010 specific terms of reference were developed in order to ensure the review of clinical governance was progressed across the Trust.

The terms of reference had eight specific objectives:

- **Objective 1** - To examine compliance and evidence of meeting CQC Essential Standards of Safety and Quality and how this information is shared with stakeholders.
- **Objective 2** - Independent assessment of the robustness of the Trust's Clinical Audit function.
- **Objective 3** - Independent assessment of the provision and monitoring of mandatory training across nursing, medical and non clinical staff.
- **Objective 4** - Independent assessment of the robustness of the Trust's system for the recording and monitoring of appraisals for all staff.
- **Objective 5** - 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.
- **Objective 6** - To determine whether the Trust's strategy for Governance, Risk and Quality is fully embedded across all wards and departments in the Trust.

- **Objective 7** - 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.
- **Objective 8** - 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.

This report outlines the key findings and key recommendations from the review and the delivery of the eight objectives listed above.

2. OBJECTIVE 1 - TO EXAMINE COMPLIANCE AND EVIDENCE OF MEETING CQC ESSENTIAL STANDARDS OF SAFETY AND QUALITY AND HOW THIS INFORMATION IS SHARED WITH STAKEHOLDERS

A full review of the evidence and monitoring systems has been undertaken in relation to how we evidence and review our compliance with the CQC Regulations and the Essential Standards of Quality and Safety.

Cumbria Local Involvement Network has also reviewed the following three specific regulations with the Trust as part of assessing our systems for monitoring compliance:

- Regulation 18 – Consent to Treatment
- Regulation 19 – Complaints
- Regulation 24 – Cooperating with other providers

2.1 Key findings

2.1.1 The Trust has in place a robust system for gathering evidence to support compliance with the CQC regulations. However since the introduction of the CQC regulations, this system needs to be strengthened to highlight the regulations where evidence to ensure compliance is weak in terms of actual practice in clinical areas/departments.

2.1.2 The CQC issues providers with a regularly updated Quality Risk Profile (QRP). The QRP is a tool that gathers data from a range of national systems and sources, for example mortality rates and collates this into one place. The purpose of the QRP is to outline where risks lie, including identifying any areas of potential non compliance with the regulations. The Trust has a system to collate the information from the QRPs, however, this is not directly linked to our internal assessment on evidence to support compliance.

2.1.3 The CQC requests providers to complete ‘Provider Compliance Assessments’ (PCAs) for each of the regulations. The Trust has started to do this but still has progress to make in terms of transferring the previous evidence system to the specific PCAs for the regulations.

2.1.4 In addition to the evidence systems, the Trust does not have in place a robust process for carrying out internal spot checks to assess whether the evidence supports what takes place in practice.

The CQC undertake spot check assessments, however, the Trust should be reliant on its own internal spot check assessments.

2.1.5 The Essential Standards of Quality and Safety have been issued across the Trust with specific posters being designed to explain the essential standards. However, it is not clear as to how this information is relayed back to patients attending the Trust.

2.2 Key recommendations

2.2.1 The Trust system for monitoring compliance with the CQC regulations requires enhancing to triangulate the three core aspects of reviewing compliance:



2.2.2 The Trust Board should receive a traffic light report on the status of compliance with the regulations in order for these to be reviewed in the context of the overall performance of the organisation. This should also include any key involvement or correspondence with the CQC on any regulations to ensure transparency of reporting to the public on how the Trust is performing against the regulations.

2.2.3 The Essential Standards of Quality and Safety should be included in each patient information leaflet to ensure they are explicitly highlighted to all patients.

3. OBJECTIVE 2 - INDEPENDENT ASSESSMENT OF THE ROBUSTNESS OF THE TRUST'S CLINICAL AUDIT FUNCTION

Internal Audit has carried out an independent assessment of clinical audit and have concluded that overall there is limited assurance that Clinical Audit is fully embedded within the governance system or that there is clear evidence of follow up and implementation of recommendations across the Trust.

3.1 Key findings

- 3.1.1 The Trust has in place a system for clinical audit which has been led from within the Divisions/individual clinical directorates. The report from internal audit has highlighted that the functions of clinical audit which have traditionally separate to the Trust's clinical governance system and need to be fully integrated.
- 3.1.2 The Trust has in place a Clinical Audit plan which was approved for implementation; however the lack of managerial resource and integration of this function into the clinical governance team has not provided adequate monitoring to assure the organisation that the outcomes from clinical audits are followed up in terms of improving clinical practice.
- 3.1.3 It is important to outline that there were some good examples of where local clinical audits were developed and improvements made the clinical practice as a result, however, this was not consistent or 'joined' up across the organisation.
- 3.1.4 The reporting on the outcomes from clinical audit and the role of the Governance Facilitators have started to include the reporting of clinical audit activity, however this requires further development across all the Divisions.

3.2 Key recommendations

Internal audit have outlined the following recommendations for improvement which have been approved by the Trust.

- 3.2.1 The Trust should develop a Clinical Audit Strategy to cover:
- The objectives of clinical audit
 - The benefits of clinical audit to the Trust and to patient care
 - How the Trust will embed clinical audit into its governance framework
 - How the improvements in patient care arising from clinical audit can be measured against the Trust's objectives in line with best practice.
- 3.2.2 The Trust should proceed with recruiting a Clinical Audit manager.
- 3.2.3 The Trust needs to encompass all clinical audit activity in a comprehensive process so that Trust objectives can be prioritised and clinical audit is embedded in governance throughout the Trust.
- 3.2.4 The Trust needs to establish a more formal process of review for clinical audit results that demonstrates how clinical audit is embedded in governance processes and how the Trust is striving for best practice.

- 3.2.5 Clinical Audit needs to be embedded within governance reporting arrangements across divisions and up to the Governance Committee.
- 3.2.6 Where action plans are produced from clinical audits, then a more robust system of monitoring their implementation needs to be developed.
- 3.2.7 The Clinical Audit data base needs to be used to generate more reports on audits and their status to be included within divisional governance arrangements so that a true picture of clinical audit activity can be seen.
- 3.2.8 Clinical audit is more than medical staff CPD and junior doctors' training. It should cover all professions and form an integral part of the assurance process.

4. OBJECTIVE 3 - INDEPENDENT ASSESSMENT OF THE PROVISION AND MONITORING OF MANDATORY TRAINING ACROSS NURSING, MEDICAL AND NON CLINICAL STAFF

Internal Audit has carried out an independent assessment of mandatory training and has concluded that overall there is limited assurance that the Trust has in place robust systems for the provision of mandatory training. There has been a considerable amount of work undertaken within the Education and Training department to develop a directory and link it to e-learning, but the take up across the Trust is very low with only a few departments/wards actually implementing this effectively. In the case of induction training, there is a system in place but the evidence that it is followed through, particularly for local induction needs to be improved.

In addition to this internal audit also concluded that there is no assurance that the Trust has in place a robust system to monitor training. Although a reporting system has been designed it still needs considerable work. It is reliant on other systems input to produce a comprehensive report on training across the Trust.

4.1 Key findings

- 4.1.1 The actual reporting figures for mandatory training are low and are not currently an integral part of performance monitoring from a workforce performance monitoring perspective.
- 4.1.2 The Trust has made significant progress in the systems to support the development of training needs analysis across the organisation, however, this requires further support and focus to ensure clinical staff and departments have clarity on what is required from both a mandatory and statutory training perspective.
- 4.1.3 The policy for mandatory training has been reviewed however greater focus needs to be applied as to how staff access what is required and the methods for delivery.

- 4.1.4 The Trust is trying to provide the majority of training via e-learning to minimise the time members of staff need to take from the ward areas. However, this should be reviewed to ensure the adequate time and resource is given to training staff on the organisations priorities for mandatory training.
- 4.1.5 A key issue identified from speaking to members of staff was the issuing of releasing staff particularly from clinical areas.
- 4.1.6 The overall planning and delivery of education and training is not adequately linked to the overall clinical governance of the organisation and needs to be joined up to ensure the key priority areas for training ensure we improve the quality and safety of care given to patients.

4.2 Key recommendations

Internal audit have outlined the following recommendations for improvement which have been approved by the Trust.

- 4.2.1 The Trust needs to promote the interactive Training Needs Analysis (TNA) from the top down to reinforce the importance of completion of mandatory training and facilitate access for staff who may have difficulties using computers. The Trust should also ensure that priorities for training are explicit.
- 4.2.2 Line Managers need to be responsible for ensuring that their staff complete training in line with the TNA. This will be facilitated once reports can be produced, but some support needs to be made available in the meantime from the education and training (E&T) department.
- 4.2.3 The recommendations from the Francis Report need to be formally monitored and reported to the Governance Committee in respect of Education and training to strengthen patient care.
- 4.2.4 The policy on mandatory training should refer to the legislation behind statutory training requirements which are included within the policy.
- 4.2.5 The reporting of mandatory training needs to be monthly and broken down in such a way as to enable line managers to monitor their staff. Reporting should be comprehensive so that all areas of mandatory training can be monitored. It is as important to know whose training is still outstanding as well as who has completed it. This should be broken down for all staff groups including medical staff, in order for Associate Medical Directors and Clinical Directors to have clarity on the position on mandatory training for medical staff.
- 4.2.6 The Access database for reporting E&T should be reviewed as an interim measure and the Trust should invest short term resources (potentially internally) to allocate competencies to posts within the ESR system to ensure a more robust longer term reporting procedure.

- 4.2.7 There needs to be formal written procedures on the process for extracting data from OLM to the access data base and then into excel reports as the current system is almost entirely dependent on one individual.
- 4.2.8 There needs to be closer follow up of attendance at induction training and E&T should have the support of HR to ensure that induction both corporate and local is properly signed off.
- 4.2.9 The local induction for locum and medical staff should be prioritised immediately to identify a clear process and checklist for short term, medium term and long term locums.
- 4.2.10 Line managers must take more responsibility to ensure that staff complete mandatory training and this should be monitored within their own areas by the individual directors responsible. The role of the HR Business Partners in relation to the Divisional Support and reporting on this area needs to be clarified.
- 4.2.11 There needs to be specific set criteria for the induction of locum staff covering short, medium and longer term appointments.
- 4.2.12 Medical staffing should ensure that all locum agency staff undertake the necessary mandatory/local induction.
- 4.2.13 The Trust should set a target of mandatory training to demonstrate CQC requirements and reporting/monitoring against this target should be by the Governance Committee on a regular basis.
- 4.2.14 The status of medicines management update training requires immediate action.

In addition to the recommendations from Internal Audit, the Trust has also outlined the need to:

- 4.2.15 Clarify the study leave and Supporting Professional Activity (SPA) time (for medical staff) to ensure all staff have dedicated time to undertake mandatory training.
- 4.2.16 The information given out at local induction regarding how the organisation is governed should be updated.

5. OBJECTIVE 4 - INDEPENDENT ASSESSMENT OF THE ROBUSTNESS OF THE TRUST'S SYSTEM FOR THE RECORDING AND MONITORING OF APPRAISALS FOR ALL STAFF

Internal Audit has carried out an independent assessment of the system for recording and monitoring appraisals for all staff and have concluded that overall limited assurance is given on the adequacy of the systems in place for the provision and monitoring of recording and reporting of appraisals. In October 2010 Internal

Audit concluded that there was significant assurance was given that the Trust has a well designed appraisal system.

5.1 Key findings

- 5.1.1 The Trust has made significant progress with the uptake of appraisals for all staff including medical staff.
- 5.1.2 During the review the systems for recording medical staff appraisal have been improved and will continue to be developed in line with the organisations requirements for medical revalidation.
- 5.1.3 The reporting system within education and training and the linkages with the HR team have continued to be refined to ensure the accuracy on the figures reported, however this needs to be fully resolved to ensure the Trust has a robust system that is not reliant upon individuals.

5.2 Key recommendations

Internal audit have outlined the following recommendations for improvement which have been approved by the Trust.

- 5.2.1 The Trust must ensure that there are robust support arrangements with written procedure and system notes in place to maintain the access data base for appraisal recording until manager self serve is rolled out in ESR. Leavers should be deleted from the access data base
- 5.2.2 To provide a comprehensive report on appraisals, the Trust needs to capture appraisal information for all staff, and needs to decide how it will do so. This will require greater liaison with the section responsible for medical staff appraisals.
- 5.2.3 Within the HR Directorate the HR Business Partners have a direct link to clinical managers in the Divisions and are ideally placed to ensure appraisals are high. If the good practice in the surgical division was extended across the other divisions then overall appraisal rates would increase.
- 5.2.4 Responsibility for recording medical and dental staff appraisals needs to be clarified.
- 5.2.5 HR Medical staffing should ensure that all locum staff appointed have had an appraisal and only use agencies on the NHS standard contract that stipulate this condition. Where locums have been in place for 12 months the Trust should arrange appraisals for them.
- 5.2.6 The Trust should establish a system for third party assurance on medical appraisals for those not directly employed by the Trust.

- 5.2.7 The policy for Appraisals should be updated. All posts require a competency framework if appraisals are to be effective and this is also true if e-KSF is to be developed.
- 5.2.8 A new policy for Medical Appraisals should be prepared and approved as part of the Trust's published policies procedures (in accordance with the Trust's preparation for medical revalidation).
- 5.2.9 The new role for the Medical Director Office Manager should be more robust and provide clarity on the links between Medical Staffing in HR and Education & Training.
- 5.2.10 The format of appraisals needs to be better structured and linked to clinical divisions to deliver positive outcomes on staff development and subsequently patient care.
- 5.2.11 The training for appraisers should be updated to specifically include competency criteria. There should also be opportunities to provide staff on the appraisal process and what both sides need to put into the process to achieve the most effective outcomes.

6. OBJECTIVE 5 - 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

Internal Audit have undertaken a follow up assessment on a previous audit regarding the robustness of the Trust's systems for implementing NICE clinical guidance and have concluded that there is no robust assurance that the Trust has robust systems for recording and monitoring compliance with NICE guidelines.

6.1 Key findings

- 6.1.1 The Trust has a clinical effectiveness facilitator who leads on the registering and issuing of nice clinical guidance to consultant teams.
- 6.1.2 This database for recording NICE guidance is robust and updated on a regular basis.
- 6.1.3 The local clinical audit plan does not explicitly link to the requirements against the guidance therefore providing a potential gap between the guidance and what has been audited or reported on within the Trust.
- 6.1.4 The gaps already identified in the clinical audit systems across the Trust do also link with how clinical effectiveness is managed across the organisation.

6.2 Key recommendations

Internal audit have outlined the following recommendations for improvement which have been approved by the Trust.

- 6.2.1 The Trust should reflect new organisational structures in policy for implementing clinical guidelines including key committees.
- 6.2.2 Complete the review of the NICE Guidelines policy and procedure.
- 6.2.3 Consider restructuring the NICE Manager's "Register" of Guidelines so that the spreadsheet records and evidences the implementation process from start to finish; and the current assessment of Trust compliancy.
- 6.2.4 Consider moving the NICE manager's place in the organisational structure so that the position and its reporting responsibilities lie within the Medical Director's Office.

In addition to the recommendations from Internal Audit, the Trust has also outlined the need to:

- 6.2.5 Ensure clinical effectiveness is a key component of clinical audit within the Trust.
- 6.2.6 Provide a baseline assessment of the NICE guidelines with the respective divisions to ensure the clinical directorates have reviewed and audited their practice against the guidelines.

7. OBJECTIVE 6 - TO DETERMINE WHETHER THE TRUST'S STRATEGY FOR GOVERNANCE, RISK AND QUALITY IS FULLY EMBEDDED ACROSS ALL WARDS AND DEPARTMENTS IN THE TRUST

The governance team have reviewed how well the Trust's governance strategy is embedded across the organisation. It is important to highlight that significant progress has been made on developing a new governance strategy for the organisation which is now focussed on six core pillars of governance.

7.1 Key findings

- 7.1.1 The new strategy and core pillars of governance provide a clear framework for all staff to follow in terms of how we govern the organisation.
- 7.1.2 The reporting arrangements for governance have been reviewed to ensure these reflect the core pillars of governance from the clinical divisions to the Trust Board.

This has made significant improvements as to how clinical governance is reported within the organisation and provides the Governance Committee with greater assurance on the key governance issues across the organisation from a 'ward to board' perspective.

- 7.1.3 The strategy still requires further embedding which has commenced by introducing governance road shows for each of the 'pillars'.

- 7.1.4 Specific governance folders have been issued to all wards and departments to ensure the strategy and core pillars are described and provide a tool that all staff can use and add to within their areas.
- 7.1.5 The Divisions have a regular item on governance at their Divisional Board meetings. However greater clarity and direction is required to ensure the key governance issues are reported and review on a consistent basis, for example through developing local quality dashboards.

7.2 Key recommendations

- 7.2.1 The governance road shows should be complete by November 2011 to ensure that the senior staff have received detailed information on each of the core pillars and what it means for their role and the management of their teams/departments.
- 7.2.2 A survey should be undertaken in quarter four of 2011/2012 to measure the knowledge of all staff in relation to the strategy and general governance across the organisation.
- 7.2.3 Specific information on the Trust's governance arrangements should be included in the induction and mandatory training packages.
- 7.2.4 Guidance should be issued to Divisions on what should be reported on monthly at Divisional level from a governance and quality perspective.

8. OBJECTIVE 7 - 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

A full review of the support structures and workforce resources for clinical governance has been undertaken. The consultation with the staff potentially affected by this review commenced in January 2011, which has included individual meetings with members of staff and staff groups to gain their views on where improvements or changes need to be made.

A key driver in this objective was to determine whether the Director of Nursing and Medical Director have a robust support structure to discharge their duties in terms of the quality and safety of care given to patients. It is important to highlight that some organisations are looking to closely align the duties and responsibilities of the Director of Nursing and Medical Director in terms of their unequivocal responsibilities for clinical governance.

It has also been important to ensure the recommendations outlined in the Medical Revalidation requirements are taking into consideration on implementing a new structure. Each provider has now nominated a Responsible Officer (RO) who, in most organisations in England and for this Trust, is the Medical Director.

Responsible officers, in England, are expected to be integral to improving the quality of care and focus on the three core components in *High Quality Care for All* (DH 2008):

- Patient safety – by ensuring doctors are maintaining, and raising further, professional standards.
- Effectiveness of care – by supporting professional ethos to improve further the effectiveness of clinical care.
- Patient experience – by ensuring patients' views are integral to evaluations of a doctor's fitness to practise.

The development of the RO role is part of the White Paper reform *Trust, Assurance and Safety* (2007). It seeks to raise the already high standards of the majority of professionals, while ensuring that the small number of staff who are not able to meet those standards are swiftly identified and then dealt with fairly and effectively and, where appropriate, are supported to get back on track. In support of this the RO role will:

- Ensure doctors who provide care are safe;
- Ensure doctors are properly supported and managed in sustaining and, where necessary, raising their professional standards;
- For the very small minority of doctors who fall short of the high professional standards expected, ensure that there are fair and effective local systems to identify them and ensure appropriate remedial, performance or regulatory action to safeguard patients; and
- Increase public and professional confidence in the regulation of doctors.

It is, therefore, important that the RO role has a robust infrastructure to implement the new requirements for medical revalidation and deliver the key clinical governance priorities that are set out in national guidance in relation to medical revalidation.

Finally, it is important to highlight that any proposed changes in workforce must be developed in the context of the pending acquisition as well as the organisation being in financial turnaround. Whilst the senior (Director) roles within the structure will change or cease once the organisation is acquired it is essential that the Trust implements a new structure to ensure a smooth and safe transition to a new organisational form.

8.1 Key findings

- 8.1.1 The existing support structures for both the Director of Nursing and Medical Director require strengthening. There are some key areas to address both in terms of capacity/resources as well as the re-focussing of some existing roles within the structure. The key areas which require strengthening include:

- The Director of Nursing and Medical Director structures should be more closely aligned and linked in order to provide a single structure for the management of clinical governance across the Trust.
- Additional resource is required to improve the support for medical governance and the monitoring of clinical standards across the Trust. This includes the central co-ordination of key systems for example consultant appraisal, job planning and monitoring of CHKS data.
- Additional information analyst resource is required to support the production of the quality dashboards as well as the monitoring of data on key systems such as Ulysses and CHKS.
- The Deputy Directors of Nursing roles should be included in the governance structure to ensure these roles are fully integrated to the development and implementation of clinical governance across the Trust.
- The existing nursing quality posts within the structure should be re-focused in accordance with above to ensure we develop the quality improvement skills at direct patient care level.
- The complaints department requires some investment a re-focussing of roles to ensure the Trust focuses on patient relations issues as a whole and not just complaints.
- The functions within litigation and complaints should be reviewed to ensure value for money but also expertise in this area.
- The roles within clinical audit and effectiveness need to be reviewed to ensure the capacity for this important area of clinical governance is provided on a Trust wide basis and that it is fully integrated within the governance structure.
- The roles of adult and paediatric safeguarding require strengthening and should be part of the governance structure for the Trust.
- There should be a recognition that other key departments and functions have a key role to play in terms of the overall the clinical governance of the organisation, for example education and training and medical staffing. Work should be undertaken to develop these links as part of implementing a new structure.

8.2 Key recommendations

- 8.2.1 A new governance structure for the Trust should be implemented which addresses the above points.

9. OBJECTIVE 8 - 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

To ensure the review of clinical governance included direct feedback from consultant staff on this important objective, the Medical Director has undertaken a survey of consultant staff to ensure this review includes director feedback from the consultant medical staff on our current position with how this objective is being carried out in the Divisions.

9.1 Key findings from the survey has highlighted that

- 9.1.1 The majority of clinical teams have set clinical outcome measures which are reviewed within their specialty. However, there is still improvement required to ensure these are consistently set and reviewed on a regular basis.
- 9.1.2 There is improvement required on the local clinical audit plans that are in place for individual specialties.
- 9.1.3 The majority of consultants confirmed that they have robust peer review systems in place including mortality and morbidity meetings, which are predominantly facilitated by the consultant team. The frequency for these meetings did vary.
- 9.1.4 A high proportion of the consultants who responded did not regularly review their individual consultant information on CHKS.
- 9.1.5 The majority of consultants who responded confirmed that they were informed about risks, incidents, near misses and complaints within their directorates, which were also reviewed by the specialty team.
- 9.1.6 The results also highlighted that there was a need to improve the communication from the divisional boards to the consultant teams, particularly on governance issues.

9.2 Key recommendations

- 9.2.1 The investment required in the medical director's office is essential to ensure the Trust develops robust systems to support the monitoring of clinical standards across the clinical specialties.
- 9.2.2 The Trust has already identified that the development of a Trust wide framework for mortality and morbidity is required and is a specific quality priority for this year.
- 9.2.3 Clear guidance and direction should be given to ensure the key issues discussed at Divisional level are relayed back to individual clinical directorates.

9.2.4 Further work is required on the development of clinical outcome measures across individual specialties to ensure they link to local clinical audit plans and are formally reviewed within the clinical teams.

10. CONCLUSION AND NEXT STEPS

The review of clinical governance has involved undertaking a 'root and branch' review of key areas across the Trust. Eight specific objectives were identified to form the basis of the review which is now complete. The review has highlighted some good examples of practice as well as highlighted the progress the Trust has made during the last 18 months to strengthen its governance arrangements.

This report focuses on the key findings and more importantly the recommendations that have resulted from this detailed review. It is pertinent to highlight that implementing these recommendations will also be an important part of preparing the organisation to be acquired by an existing NHS Foundation Trust.

10.1 Next Steps

It is recommended that the following next steps are taken in order to implement the recommendations outlined in this report:

- All recommendations should be combined into a Governance Improvement Plan for 2011/12, which should be reviewed by the Governance and Quality Committee on a monthly basis by exception.
- Audit Committee to review the detailed Internal Audit reports referred to in this report.
- Key findings of the review to be shared with all staff.
- Key findings and details of the review to be shared with key stakeholders.
- New structure to be approved and implemented.

Ramona Duguid
COMPANY SECRETARY

July 2011