North Cumbria University Hospitals NHS
NHS Trust

Appendix 1

REVIEW OF CLINICAL GOVERNANCE ANNUAL REPORT 2011/12

1. INTRODUCTION

In January 2011 the Trust Board approved specific terms of reference to undertake a review of clinical governance across the Trust. The review was based on the following core 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.

In July 2011, the Trust Board approved the outcomes from the review and associated recommendations, which have been implemented during the last eight months.

This report provides a summary of the key actions which have been implemented against the objectives with the detail on the position of the recommendations provided in Appendix 2 of this report.

The report also outlines the priorities for 2012/13 to ensure the improvements made are sustained and further developed during the forthcoming year.

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

This objective resulted in three recommendations for implementation, which are summarised below:

2.1 Progress against 2011/12 recommendations

The Trust system for monitoring compliance with the CQC regulations has seen a significant improvement during 2011, with greater focus being placed on the outcomes from the Quality Risk Profile (QRP) and the position of the Trust in relation to the Provider Compliance Assessments (PCAs).

In addition, revised reporting to the Trust Board has been introduced during the year to provide greater clarity on the Trust's position with meeting the essential standards set out by the CQC. This report has been further enhanced at the end of quarter four to allow even further clarity on the areas in the PCAs which still require further work evidence.

The Trust has introduced specific communications material in the entrances to the two hospitals as well as specific posters on the ward to promote the essential standards of care and more importantly empower patients and relatives to challenge or raise concerns if they feel these standards are not being met.

2.2 Priorities for 2012/13

The key priorities for 2012/13 relate to the preparation of the Trust being acquired and therefore being part of the Monitor regulatory regime and the need to embed the monitoring and accountability of CQC compliance within the clinical business units:

- Monitoring of compliance to be extended into the three clinical divisions to allow greater ownership and assessment of the standards in relation to individual clinical services and departments.

- Trust reporting and monitoring framework to be developed in accordance with the Monitor Compliance Framework and associated governance rating.

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

Internal Audit carried out an independent assessment of clinical audit and 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. This resulted in eight recommendations being made as part of the review.

3.1 Progress against 2011/12 recommendations

The Trust has developed a Clinical Audit Strategy, which was approved in December 2011. This strategy will continue to be reviewed and updated to ensure the national priorities for clinical audit are included on an annual basis.

The Trust recruited a Clinical Audit Manager in April 2011; however the person left the Trust in January 2012. The Head of Medical Governance and Clinical Standards has been directly overseeing the management of clinical audit and reviewing the options for replacement of this post in the medium to longer term.

The Trust has developed a new clinical audit policy to provide clarity on how clinical audit is co-ordinated and carried out across the Trust. In addition, a greater focus has been placed on the divisional reporting on progress with delivering their clinical audit priorities, which still requires further development during 2012/13.

The Trust policy describes how results from clinical audit will be reviewed. The Head of Medical Governance and Clinical Standards has reviewed all of the outcomes from clinical audit per division during quarter four; this has highlighted a number of service improvement plans, which are currently being reviewed in terms of the status of the plans but also any associated risks within the clinical divisions.

Specific information on clinical audit is now included in the quarterly governance reports to monitor divisional performance. This has also included generating improved reports from the clinical audit team.

The Trust has started to engage a wider multidisciplinary group of staff on clinical audit, however this will need to remain a key focus are during 2012/13.

2.2 Priorities for 2012/13

It is recognised that the position of clinical audit across the Trust has been considerably weak for a number of years. The improvements made during 2011/12 have resulted in stronger foundations being set for clinical audit across the Trust, which now need to be embedded. Therefore the key priorities for 2012/13 include:

- Development of the clinical audit plan for 2012/13 with identified clinical leads, including the national clinical audits required for the 2012/13 quality account.

- Produce a status report on the position of improvement plans arising from clinical audits.

- Establish and monitor the clinical directorates on how the outputs from clinical audit are reviewed and reported through the governance structure of the Trust.

- Performance manage the clinical divisions on the delivery of their audit plans and action plans arising from clinical audit.

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

Internal Audit carried out an independent assessment of mandatory training and concluded that overall there is limited assurance that the Trust has in place robust systems for the provision of mandatory training. This resulted in fifteen recommendations being made from the review.

4.1 Progress against 2011/12 recommendations

A significant amount of work has been undertaken to develop and engage staff with the use of the interactive Training Needs Analysis, which is in place for all staff. In addition, the guidance from NHS North West on the Core Skills Framework has been adopted to bring the Trust in line with other NHS Trusts. In addition, specific priorities for 2012/13 have been agreed which include Resuscitation Training, Medicines Management, Safeguarding and Information Governance. Staff sessions on how to use the TNA are ongoing, including how managers use this as a tool to monitor the training requirements for their staff.

The recommendations highlighted in the Francis Report in relation to education and training have been reviewed by the senior nursing team and relate to the releasing of staff and prioritisation of training, particularly for ward staff.

The Trust Mandatory Training Policy has been updated, including the protected learning time policy for all staff.

Improvements have been made on the reporting of mandatory training to both the Trust Board and the Divisions, however improvements are still required in this area for 2012/13. The Trust is still working on an access database to record training and there is no plan to move to the recording of training on ESR. Arrangements are in place for staff who do not attend training, however improvements could also be made to the robustness of this and escalation to line managers.

The checklists in place for locum medical staff have been improved during the year to ensure key issues regarding training/competencies are identified. This will continue to be monitored with 'spot checks' being undertaken from the Medical Director's Office during 2012/13.

As part of the turnaround work, a revised job planning policy has been drafted, which clarifies the position on Supporting Professional Activity (SPA) time. This policy has not yet been fully implemented, however it is anticipated this will be during quarter one of the new financial year.

4.2 Priorities for 2012/13

The position of mandatory training across the Trust has remained a key challenge for many years both in terms of the performance management of mandatory training but also the integration of mandatory training into the wider clinical governance agenda.

Training uptake levels remain significantly weak in a number of areas and this remains a key risk for the organisation. Whilst improvements have been made during 2011/12, there remains a significant amount of work still to do to improve the levels of training for all staff groups. Therefore the key priorities for 2012/13 include:

- Greater performance management of divisions in the training levels for all staff groups against the specific training priorities set for the Trust.

- A specific report on mandatory training to be introduced for medical staff to ensure SPA time is also being used for their mandatory training requirements.

- Due to the potential risks associated with the low uptake of mandatory training levels, which has been a challenge for a number of years, improved reporting should also be introduced into the monthly performance reports to provide greater emphasis on the actions in place to address areas which have low uptake of training levels.

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 carried out an independent assessment of the system for recording and monitoring appraisals for all staff and 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. This resulted in eleven recommendations for improvement following the review.

5.1 Progress against 2011/12 recommendations

The Trust has in place a system for recording staff appraisal rates, however this is not linked to the main ESR system. Improved reporting on appraisal figures to the divisions has been introduced which are reviewed at the monthly divisional reviews.

In addition, a significant amount of work has been undertaken to improve the recording and monitoring of medical staff appraisals. A new medical staff appraisal policy has been drafted and is currently out for consultation. Greater co-ordination with medical staffing has also been introduced to validate medical staff lists and ensure these are reviewed on a regular basis for all Trust employed medical staff and long term locums. A key factor in achieving more joined up working with medical staff has been the staff appointments made to the medical directors office.

The Trust policy for appraisals has been updated as well as the training to clarify the responsibilities of the appraiser and appraise.

5.2 Priorities for 2012/13

Whilst progress has been made in a number of areas in relation to staff appraisal, the appraisal rates remain low/below standard in a number of clinical areas. It is important therefore that the position on appraisal rates, but also the feedback from staff on the value of appraisal, continues to be a key focus for 2012/13.

- All clinical departments and directorates with appraisal rates below 50% to produce a detailed action plan as to how these will be improved during quarter 1 and 2 of 2012/13.

- New medical staff appraisal policy to be implemented in preparation for medical revalidation.

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 undertook a follow up assessment on a previous audit regarding the robustness of the Trust's systems for implementing NICE clinical guidance and concluded that there is no robust assurance that the Trust has robust systems for recording and monitoring compliance with NICE guidelines. This resulted in thirteen recommendations for improvement following the review. 1

6.1 Progress against 2011/12 recommendations

Since the introduction of new posts within the Medical Director's office a significant amount of work has been undertaken on reviewing the current position of NICE guidance and implementing the recommendations from the review.

A new policy has been written which reflects the new roles in the governance structure and outlines a clear process for the management of NICE guidance across the Trust. This has also resulted in clinical effectiveness/position against NICE sitting fully in the portfolio of the Medical Director's office.

The Trust has had in place a NICE register, which has undergone a significant review and has been revised. The key focus has been on NICE Clinical Guidelines as a starting point which is being reviewed in terms of clinical leads and evidence in place to confirm the Trust is compliant. It has been important to focus on this recommendation in order to establish a baseline for work to be taken forward during 2012/13. Specific dates have been added to the register to allow greater clarity on when the position of compliance was last reviewed by the clinical specialty.

The governance team are now fully interlinking incidents and complaints against NICE guidance to ensure issues are checked against the best practice guidance.

The outcomes from clinical audit described above where improvement action plans are required or where 'not good practice' has been identified has been shared with the clinical divisions in quarter four 2011/12. A key task for the divisions and business units is risk assessing any areas of poor practice against the NICE guidance.

6.2 Priorities for 2012/13

Following the new staff appointments made to the Medical Director's office, significant progress has been made against the recommendations, which have not been acted on for a number of years. However the clinical audit improvements we have made along with improving our system for monitoring NICE compliance needs to be built on even further during 2012/13 in order to fully bring this aspect of clinical governance up to the required standard, which will involve greater accountability from the clinical directorates. The priorities regarding NICE and clinical effectiveness for 2012/13 include:

- Position on NICE compliance will be formally reported to the Trust Board as a key quality performance measure during 2012/13.

- The updated register will be reviewed by the Governance and Quality Committee in quarter 1 of 2012/13 as part of the Divisional quarterly reports, to ensure the divisional ownership and embedding of NICE guidelines relating to their clinical services.

- The outcomes from clinical audit which link to the compliance with NICE guidelines will be specifically reported on at the Clinical Standards Sub Group.

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. This has included the embedding of the core pillars of governance across the Trust. The review highlighted four recommendations for implementation.

7.1 Progress against 2011/12 recommendations

Information on the Trust's core pillars of governance has been introduced in the staff induction and the governance reports across the Trust have been tailored to reflect the core pillars and ensure the over arching framework is being used across divisions and individual directorates.

Specific road shows against the core pillars have been carried out in key areas, however, these will continue during 2012/13 to ensure continued engagement and learning of the staff in relation to the Trusts' governance strategy.

7.2 Priorities for 2012/13

The Trust's strategy for governance continues to be embedded with staff now using the core pillars as a framework to apply to their individual clinical area. However, it is important we continue to embed the strategy across the Trust. The priorities for the governance strategy for 2012/13 include:

- Continuing with the staff road shows for the core pillars of governance during July 2012.

- Conduct a 'staff feedback' survey during quarter 2 on the general knowledge of the Trust's governance framework.

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 which has resulted in a new structure being introduced for governance during December 2011. This has resulted in the following key improvements:

- Alignment of the Medical Director and Director of Nursing for the responsibility of clinical governance
- Dedicated Director lead to co-ordinate governance across the Trust
- Additional roles introduced to Medical Director's Office
- Complaints department centralised on one site
- Clinical Audit Facilitators now aligned to an individual clinical division
- Dedicated litigation lead
- Head of Patient Safety and Clinical Governance role redefined
- Compliance Manager role redefined

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, feedback was obtained from consultant staff on the arrangements in place within individual specialties. This resulted in four recommendations for implementation.

9.1 Progress against 2011/12 recommendations

Investment and improvement in the Medical Director's office has been introduced as part of the review to improve the focus on clinical standards and effectiveness as outlined in earlier sections of the report. This has included a greater focus on review mortality across the Trust through a single framework.

The content of clinical governance activity at directorate and divisional board level varies and it is clear from the improvements we have made that a key challenge for the clinical governance agenda is how this is embedded and owned within the clinical directorates.

9.2 Priorities for 2012/13

The Trust will be going through significant changes in preparing for the acquisition, which will be a significant learning curve for the clinical directorates. The key priorities for 2012/13 have been identified:

- Clinical divisions should undertake a review of how the core pillars of governance are discussed and reviewed within their clinical directorates. This should include the identification of the core clinical governance meetings that take place within their division and how these report to their divisional boards.

10. CONCLUSION

The review of clinical governance has identified a number of basic systems which required significant improvement and have done for many years. Good progress has been made during the year on addressing the recommendations from the review. Out of the 61 recommendations all have been implemented with the exception of 8 of the recommendations, which are amber as at 31 March 201.

The Trust has made the improvements to its governance arrangements during a year of significant challenges and competing priorities given the strategic issues facing the organisation during the year.

As part of being acquired, the governance arrangements will need to continue to be developed with a specific emphasis being placed on how far the arrangements are embedded within the clinical directorates and the accountability in place within individual clinical specialities. This is to ensure the requirements set out by Monitor for quality governance can be evidenced across West Cumberland Hospital and the Cumberland Infirmary.

The priorities for 2012/13 which have been identified in this report will form the main basis of the governance objectives for the year.

11. RECOMMENDATION

That the Board notes the progress made on implementing the governance review and approves the key priority areas identified in the report to form the main basis of the governance objectives for 2012/13.

Ramona Duguid
Acting Director of Governance and Company Secretary

May 2012