INTRODUCTION

Governance is the responsibility of all staff but statutory responsibility, corporate ownership, direction and facilitation lies with the Trust Board. The purpose of governance is to ensure the continuous improvement in the quality of care and service delivery to the community we serve. The review by the Commission for Health Improvement (CHI) is an integral element in achieving this outcome. Portsmouth Hospitals Trust is currently undergoing its first CHI review. The purpose of this paper is to provide the Board with:

1. An overview of CHI progress
2. Specific issues identified
3. Areas of notable practice
4. Action already taken
5. Action plan

CONTEXT

The national drivers for change have given rise to a complex local agenda with which the Trust is faced. This has adversely impacted on stability. In the light of both these matters, the Trust acknowledges that there is a need to build the confidence of all key stakeholders across the health and social care economy if we are to successfully manage and deliver the agenda in partnership. Internally, the Trust has moved on significantly since the start of the review. In part this has been as a direct result of appointments to the two posts of Clinical Governance Manager and Head of Risk Management, Complaints and Legal services. A number of new appointments have also been made at Executive level that has further strengthened the strategic capacity of the organisation. Whilst being mindful of the external agenda, recent efforts have concentrated on addressing the internal infrastructure and culture. Inevitably this process is evolutionary requiring both direction and focus. We are mindful of some deficiencies particularly around ownership of the emerging structure and the appointment of appropriate people to help in the delivery of the agenda We are confident, however, that the emerging infrastructure and change in culture will provide the means through which an effective governance agenda can be delivered.

1. An overview of CHI Progress

The CHI review process at Portsmouth Hospitals Trust (PHT) commenced on 3 September 2001 and is now in the 12th week of the 24 week programme.

Submission of Information by the Trust:

The initial part of the review was completed on 24 September 2001 and included the submission of information on the Trust's profile, strategies, business plans together with detailed information on all the components of clinical governance.

Stakeholder Meetings:

On 22 October 2001. CHI concluded public meetings in relevant localities at which members of the public were invited to talk about their experiences of PHT. In addition, CHI met with key stakeholders such as the Health Authority, Community Health Councils, Primary Care Groups/Trusts to record their experience of PHT.

Patient Diaries:

From four randomly selected consultant clinics two hundred patients were identified to complete diaries The selected patients had attended PHT, either as an in or out patient during the previous 6 months and fitted into one of the following categories

- Unplanned elderly admission (65 years or over) **Code A** clinic
- Unplanned admission (under 65 years of age) - **Code A** clinic
- Chronic Admission **Code A** clinic

- Patients on a waiting list **Code A** clinic

Each patient received a diary with a request that they record their experience whilst in the care of PHT.

Summary of Evidence

A summary was prepared from an analysis of the submitted information. It will form the brief for the site visit due to commence on 10 December 2001. The summary was received in the Trust on 31 October 2001 allowing 4 working days to review and comment on the factual content.

Selection of the Clinical Teams

CHI used the information submitted by the Trust, and the stakeholder information, to select the clinical teams on which the focus of the review will be based. These teams are not intended to be representative of the whole Trust but to provide evidence of clinical governance effectiveness. The Trust was required to nominate five areas in which teams have made good progress with clinical governance. These are:

- Diabetes and Endocrine Centre
- Department of Genito-urinary Medicine
- Accident and Emergency Department
- Directorate of Child Health
- Intensive Care Unit

The teams selected by CHI are: paediatrics; renal; general surgery with specific focus on colorectal; and A&E with particular emphasis on the preceding sub-specialities.

The Site Visit

The CHI review will commence on 10 December 2001 and will be conducted by a multidisciplinary team. The duration of the visit is five and a half days. From each clinical area selected, a team will be required to present an overview of how clinical governance is making a difference to the patients' experience of care and services. The review team will then visit all PHT sites to observe and conduct interviews with staff.

In addition, an interview schedule has been jointly agreed, to ensure that the review team meets with all key corporate members of the organisation.

Reporting

The CHI Review Team will reconvene two weeks after the site visit to agree their key findings. These will then be fed back orally to the Trust by the CHI Review Manager on the week beginning 21 January 2002. The first draft of the report will be made available to the Trust on 4 February 2002. The Trust will have the opportunity to comment on factual inaccuracies and will be required to return the report to CHI within five days of receipt. The final report will be published in March 2002.

2. Specific Issues Identified

As a result of the appointments of a number of new posts identified above the Trust undertook an informal internal review of the arrangements for governance. This coincided with the formal notification of the pending CHI review. The outcome of this identified the following themes.

The need for:

- The external agenda to be addressed, by more effective engagement with local partners. That would allow us to jointly address particular aspects of clinical services where it is perceived that there are deficiencies.

- A cultural shift. From the evidence to date it is apparent that the culture of the organisation is key to the success or otherwise of implementing governance. This requires an understanding of the nature of the current culture at an organisational, professional and team level.

- Closing the loop. The organisational framework is insufficiently developed to allow appropriate follow-up action on identified weaknesses.

- Improved patient knowledge. We know from our experience of the Patient Experience Forum there is a need for an educational agenda around patient expectations, governance and service planning and delivery.

Possible areas of weakness

Audit, Standards and Effectiveness
- Implementation of NSFs, NICE, HiMP, Care pathways and confidential enquiries -> actioned
- Assessment of ethnic health needs -> actioned
- Closing the audit loop -> actioned
- Closing the clinical indicator loop -> actioned
- Use of audit across the interface with external organisations -> actioned
- Increased mortality rates in non-emergency general surgery -> actioned
- Integrated stroke service development required -> actioned
- Increased mortality rates in radiotherapy -> further investigation required
- Day case overstay rates high -> further investigation required
- High rate of D&C and grommets -> further investigation required
- Discharge planning -> ? action plan **talk to UW**

Education, Training and CPD
- Review education and training strategy -> actioned
- Low uptake of statutory and mandatory training -> actioned

IM&T
- Appropriateness of clinical coding -> actioned
- Communication strategy -> actioned
- No ethnicity coding in PAS -> action plan
- Staff access to IT -> action plan
- Appropriate staff training for IT -> action plan
- Compliance with information for national, regional and local requirements -> action plan

Patient Involvement
- Patient views to inform governance activities -> actioned
- Patient information leaflets re surgical procedures etc-> actioned
- Patient information leaflet on complaints process -> actioned

R&D
- Activity linking to governance activity -> actioned

Risk, Complaints and Legal Services
- Inappropriate handling of complaints -> actioned
- Management of risk reporting -> actioned
- Management and review of serious clinical incidents -> actioned
- Linkage of incidents/complaints/claims -> actioned
- Lessons to be learned from complaints -> action plan
- Staff training in the handling of complaints -> action plan
- Hospital acquired infection/pressure sores to inform risk management system -> action plan

Staffing and Staff Development
- Appointments made to clinical posts, in line with identified gaps in service provision -> actioned

- Review HR strategy -> action plan

Strategy and Responsibilities

- Governance at divisional level -> actioned
- Revised governance strategy -> actioned
- Greater integration with RHH -> actioned
- Trust ownership of a just culture -> actioned
- Governance links with clinical practice ethics committee -> actioned
- Closing the loops within and between the pillars of governance -> actioned
- Availability of governance information on hospital intranet -> actioned
- Integration of clinical governance/business planning –> action plan
- Annual governance report -> action plan
- Insufficient recognition of inequalities – service and staffing –> action plan
- Corporate policy management and ownership -> action plan

3. Areas of Notable Practice

It should be noted that there are many examples of innovation and improvement in service delivery over the last few years. These include:

Corporate

- The establishment of a highly visible Health Information Centre
- Systems management of drug errors

Womens and Childrens

- The establishment of a 24 hr direct access emergency gynaecology ward
- Same day obstetric ultrasound scanning service
- Paediatric emergency service

Surgery

- HNU – Beacon site
- General Surgery sub specialised to allow free referral of elective/emergency patients between consultant pool ensures patient under care of appropriate specialist
- Preoperative assessment and multi-disciplinary working to achieve minimal in-patient stay following total hip replacement at RHH
- Nurse-led case management from preoperative assessment to discharge in urology/general surgery to enhance the patients' experience

Medicine

- Expansion of the rapid access chest pain clinic
- Joint development with PCT colleagues for a Consultant nurse in diabetes
- Nurse Specialist in Rheumatology to improve quality of care through rapid patient access and increased throughput.
- One stop clinic for a range of cancer patients
- Nasal support ventilation on HDU preventing patient transfer to ITU
- Development of a nurse led outreach service, including clinics

4, Action already taken

OBJECTIVE	ACTION TAKEN	LEAD
Corporate		
Corporate ownership of policies	Addressed by sub-group of clinical governance committee	Medical Director
Mechanism to ensure all pillars of governance are linked	Through clinical governance committee and directorate reviews	Medical Director

Trust Board in regular receipt of National Patient Surveys Corporate framework for dealing with decontamination issues are in place (comply with HSC2000/032)	6 monthly updates to Trust Board by PALS manager Long term strategy in place which covers • Equipment and facilities • Policies and procedures • Training • Purchasing • Controls Assurance - review	Corporate Affairs Manager Deputy Director of Planning (Director of Capital and Estates)
The Trust is able to monitor care performance at clinical service level	Divisional reviews cover • Audit • Cancer patient master index • CEPOD • CHKS/CiRiS • Peri-natal mortality • POSSUM • Risk Management These feed into individual/team education programmes	Medical Director
Audit, standards and effectiveness		
Co-ordinated approach to undertaking audit and monitoring follow up action	Through sub-group of clinical governance committee • Review existing information systems • Maintain audit database to capture all activity • Maintain system of follow up on implementation • Receive divisional CASE reports	Clinical Audit Manager
Regular monitoring of discharge services	Feedback used to revise discharge objectives	PALS manager
Increased mortality rates in non-emergency general surgery	Follow up detailed examination of statistics and interpretation	CD General Surgery - colorectal

Development of corporate education and training strategy	Multi-professional education and training strategy has been developed	Director of Post-graduate Medical Education
Central monitoring of RMC report recommendations	• Receipt of reports of College visits and sharing of information through speciality tutor group • Co-ordination of College visits and monitoring of follow up action	
Compliance with New Deal	House Officers' situation addressed via • Change in rotas • Additional non-clinical support	
Multi-professional learning	Many examples of multi-professional learning, regularly occurring at speciality and sub-speciality level	
IM&T		
All staff to have access to internet/intranet	• Thin client PCs replacement in all ward and outpatient areas – 75% complete • QA and SMH sites outpatients – complete • QA inpatients – complete	Director of ICT
Compliance with information for national, regional and local requirements	NHS-HES common information core for submission to NHS clearing service inpatient, outpatient CDS, and WL census data compatible.	Head of Corporate Information
Ethnic coding of PAS information	Pre-March 2001 PAS system contained 'original' national codes for ethnic coding, post-2001 'new' (DSCN 21/2000) codes used	Head of Corporate Information
Current communications strategy	In place	Communications Manager
Patient Involvement		
Implementation of the recommendations from Patient Satisfaction Surveys	Appropriate follow-up action taken on all recommendations • Manpower and skill mix • Communications • Implementation of national imperatives • Environment • Hotel services • Oncology support services	PALS manager
R&D		
Establish central mechanism to monitor implementation of evidence based guidelines – NICE, ICPs, NSFs, and HiMPS	• Corporate clinical policy mechanism in place • Equality of care across boundaries These are supported through the sub-group of the clinical governance committee	Medical Director
Restored confidence in clinical information – clinical coding	Involvement of clinicians in process, namely CHKS and CiRiS project steering groups. This	Medical Director

Activity linked to governance activity	is also linked to divisional performance reviews. Through clinical governance team and committee	Clinical Governance Manager
Risk, Complaints & Legal Services		
Regular systematic feedback on adverse events • Adverse clinical incidents • Complaints • Claims	• Regular feedback and communication • Root cause analysis • Prioritising • Dedicated leads • Appropriate IM&T	Head of Risk Management, Complaints & Legal Services
Central mechanism to collect and collate verbal complaint information	Mechanism established and reported to Trust Board six monthly	Head of Risk Management, Complaints & Legal Services
Timely handling of complaints	Review of processes and skill mix to meet immediate requirements (NHSE guidance and Performance Ratings)	Head of Risk Management, Complaints & Legal Services
Public information on complaints process	Leaflet developed and available on all three sites	Head of Risk Management, Complaints & Legal Services
Appropriate use of adverse incident reporting process	• Appropriate policies • Use of adverse incident reporting process identified and monitored • Recognition that a small percentage of inappropriate use of process is inevitable	Head of Risk Management, Complaints & Legal Services
Staffing and Staff Development		
Compliance with New Deal	Work with individual specialities to ensure compliance	Director of Post-graduate Medical Education

5. Action Plan

Portsmouth Hospitals NHS Trust
Clinical Governance Action Plan: PRIORITIES

Objective	Action to be Taken	Expected Outcome	Lead	Target Completion Date
Corporate				
Integration of Clinical Governance into the business planning process	Ensure clinical governance is on the appropriate agendas for business planning Ensure business planning is on the Clinical Governance Committee agenda	Clinical Governance informs business planning	Governance Manager	March 2002
Audit, standards and effectiveness				
Ensure follow up audits undertaken are appropriate Ensure follow up action taken following audit recommendations	Ensure responsibility addressed through sub-group of clinical governance committee and divisional clinical governance structures and divisional performance reviews	• Overall improvement in the quality of patient centred care • Ownership at clinical level • Only appropriate audits are undertaken	Clinical Audit Manager	On-going
Education, Training and CPD				
Multi-professional learning takes place	• Extension of multi-professional education as appropriate from E&T strategy • Ensure the philosophy of the QuAD centre, which is based on multi-professional learning, is upheld	Further increase in multi-professional learning activities and a noticeable improvement in multi-professional working at all levels	Director of Post-graduate Medical Education	On-going

Multi-professional needs assessment An induction programme for locum, temporary and agency staff is established A reporting mechanism to fed back on performance to staff agencies is established	Regular feedback from divisions identifying specific training needs • Associated policy development • Development of inter-active IT programme • Communicate availability of IT programme	A workforce that is 'fit for purpose' All employees aware of their own responsibilities within the process	Chair of Strategic Education and Training Group Head of Personal and Organisational Development Head of Personal and Organisational Development	March 2002
IM&T				
A systematic, co-ordinated approach to the collection of clinical information	• To link with modernisation programme • Identification of an individual to lead and co-ordinate the process • Job description for previous item	Identification of areas of excellence, and areas of deficiency for action	Medical Director	March 2002
Patient Involvement				
Leaflet to be available in the appropriate language or communication medium	Identify leaflets and departmental information requiring translation or transformation Ensure all departments are aware of the procedure for the translation of documents and have access to the necessary agencies	All departments to have leaflets available in appropriate languages or communication medium All departments will be aware and have access	Equality Officer	February 2002
R&D				
Restored confidence in	Meeting to develop a shared	Restored confidence in	Medical Director	March 2002

clinical information – clinical coding	understanding and integration of clinical and IM&T needs	clinical coding		
Risk, Complaints & Legal Services				
Improved feedback on adverse events • Adverse clinical incidents • Complaints • Claims	Identify the most appropriate method by which to provide feedback	Effective feedback mechanisms in place, tailored to meet individual / divisional / speciality needs	Head of Risk Management, Complaints & Legal Services	Initiated by January 2002
	Ensure feedback if given by identified route	• Increased awareness of adverse clinical incidents, complaints and claims • Increased staff ownership of, and accountability for, risk management, risk assessment, complaints and claims • Increased pro-active management of risks/ complaints • Lessons learned and disseminated, on a Trust-wide basis	Head of Risk Management, Complaints & Legal Services	Initiated by January 2002
Appropriate use of adverse incident reporting process	Participation in Professional Issue Groups	Reduction in inappropriate use of adverse incident reporting process	Head of Risk Management, Complaints & Legal Services	Initiated by February 2002
Trust Board informed of any changes in practice, in light of complaints received	Trust Board to receive regular reports which reflect any trends in complaints and any changes made, or which	• Increase in Trust Board awareness of trends in complaints • Identification of	Head of Risk Management, Complaints & Legal Services	Initiated by February 2002

	need to be made, as a result of those trends	priorities and resources for necessary changes		
Public information on complaints	Poster to be developed for display in all public areas	Increased awareness of, and access to, complaints process	Head of Risk Management, Complaints & Legal Services	December 2001
The incidence of pressure sores is reduced	Recruit clinical nurse specialist tissue viability who will be responsible for: • Development of corporate clinical policies and guidelines • Maintenance of link nurse scheme • Increasing nursing staff knowledge of pressure sores • Ensuring implementation of benchmarking for pressure ulcers in all clinical areas	Improved identification and treatment of pressure sores	**Sarah Balchin**	From take up of appointment (asap)
Controls Assurance requirements for H&S Management are met				
Implementation of Trust-wide records strategy to meet requirements of HSC(99)053	• Prepare strategy and secure approval • Implement strategy	• Board approved strategy with supporting policy documents on all aspects of record handling • Board agreement,	Divisional General Manager, Clinical Support Services	April 2002

		with associated action plan • Formal reporting system to Trust Board agreed		
Increased uptake of BLS training	• Appropriate corporate policy • Pro-actively raising awareness of individual responsibility for undertaking regular mandatory BLS training • Pro-active support of staff to ensure release for training, through clinical managers and PDPs • Business plan bids to increase numbers of trainers	Improved uptake of mandatory BLS training	Resuscitation Training Manager	December 2001

Staffing and Staff Development				
Current appropriate Human Resources Strategy in place	Development of interim Human Resources Strategy	Effective interim strategy available	Interim Director of Human Resources	December 2001
Medical staff compliance with 'Working Time Directive'	Establish central recording and monitoring system	Compliance with standard	Interim Director of Human Resources	March 2002
Trust compliance with Race Relations Act	• Ensure establishment of a training database by which to monitor equal access to education and training	Compliance with Act	Interim Director of Human Resources	March 2002
Compliance with 'New Deal'	• Ensure proposed shared services recruitment system monitors equal opportunities • Work with individual clinical areas to meet specific identified needs • Associated vacancy to be filled	Further improvement on compliance with New Deal	Director of Post-graduate Medical Education	On-going