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Agenda Item: 9.

Integration Joint Board

Date of Meeting: 12 May 2020.

Subject: Clinical and Care Governance.

1. Summary

To put before the Board, work that has been undertaken to review the 'Terms of Reference' and the development of a 'Controls and Assurance Framework' for the Clinical and Care Governance Committee, given this is a joint committee between the IJB and NHS Orkney.

2. Purpose

The purpose of this report is to offer the IJB the opportunity to consider the work to date. The IJB needs the opportunity to be satisfied that both the Terms of Reference and the Controls and Assurance Framework are designed in such a manner, that they are content it will provide the IJB with the necessary assurance on governance for those services within its scheme of delegation. The IJB also needs to discuss and make representation on the Terms of Reference.

3. Recommendations

It is recommended:

3.1. That the IJB makes clear decisions about how it will input into the continued work of both the Terms of Reference and the Control and Assurance Framework.

And that changes required in the Terms of Reference should include:

3.2. Under section 1.5, the final sentence should read, 'This applies to health and care services either provided by NHS Orkney direct or those services provided by Orkney Health and Care on behalf of NHS Orkney or Orkney Islands Council or those services commissioned by the IJB from other sources.' This wording should also be consistent through the terms of reference.

3.3. The terms of reference should have a flow chart in respect of the different inspection activity that health and social care services can expect to be undertaken and where governance of inspection improvement activity should sit.

4. Background

4.1. The IJB and NHS Orkney have had in place, since the inception of the IJB, a joint Clinical and Care Governance Committee. This committee would have already been in situ within the Health Board prior to the IJB being operational and, as such, may explain the existing health and social care balance.

4.2. The committee does need to cover the full clinical and care governance of all services provided by both NHS Orkney and Orkney Health and Care as the delivery arm of the IJB.

4.3. On taking the Chair of this committee, the current postholder has worked hard to review and refresh the functioning of this committee. This work is now being presented to the IJB for endorsement of its governance structure and process going forward. The Terms of Reference is attached (Appendix 1). The Controls and Assurances Framework is also attached (Appendix 2).

4.4. The terms of references of other clinical and care governance groups were reviewed from across Scotland. However, there are not many partnership areas where there is a joint committee. One reason for this is that, out of the 14 Health Boards there are only six that are coterminous.

4.5. In the Terms of Reference (pg.2-3) 'Clinical, Care and Public Health Effectiveness', bullet point three, states that where there has been an inspection of health and social care services, where the conclusion is that the services are below the required standard, then this will be referred to the Quality and Safety Group. This group would not be the appropriate place for all activity from inspection activity, this group is, in the main, a clinical and NHS Orkney only membership.

4.6. There is much work to be done in respect of the Controls and Assurance Framework – this has been included as a working draft purely to give IJB members sight of how this is being developed and an opportunity to make comment.

5. Contribution to quality

Please indicate which of the Council Plan 2018 to 2023 and 2020 vision/quality ambitions are supported in this report adding Yes or No to the relevant area(s):

Promoting survival: To support our communities.	Yes
Promoting sustainability: To make sure economic, environmental and social factors are balanced.	No.
Promoting equality: To encourage services to provide equal opportunities for everyone.	Yes
Working together: To overcome issues more effectively through partnership working.	Yes
Working with communities: To involve community councils, community groups, voluntary groups and individuals in the process.	Yes

Working to provide better services: To improve the planning and delivery of services.	Yes
Safe: Avoiding injuries to patients from healthcare that is intended to help them.	Yes
Effective: Providing services based on scientific knowledge.	Yes
Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.	Yes

6. Resource implications and identified source of funding

There are no resource implications arising from return of delegating authority.

7. Risk and Equality assessment

If the joint Clinical and Care Governance Committee does not have appropriate Terms of Reference and a robust Controls and Assurance Framework, then the IJB and NHS Orkney are at risk of having limited and inadequate oversight of clinical and care governance, thus not ensuring robust risk management systems and processes being in place and effective throughout the health and social care systems in Orkney.

8. Direction Required

Please indicate if this report requires a direction to be passed to:

NHS Orkney.	No.
Orkney Islands Council.	No.
Both NHS Orkney and Orkney Islands Council.	No

9. Escalation Required

Please indicate if this report requires escalation to:

NHS Orkney.	Yes.
Orkney Islands Council.	No.
Both NHS Orkney and Orkney Islands Council.	No

10. Author

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12. Supporting documents

Appendix 1 - Clinical and Care Governance Terms of Reference DRAFT.

Appendix 2 – Controls and Assurances Framework DRAFT.

Appendix 1.

CLINICAL AND CARE GOVERNANCE

TERMS OF REFERENCE 2020-21

1.1 Purpose

To provide the NHS Orkney Board and the Integration Joint Board (IJB) with the assurance that robust clinical and care governance and risk management systems and processes are in place and effective throughout the health and social care systems in Orkney. That these systems and processes are the framework to support effective clinical and care risk management, clinical and care effectiveness, person centeredness and continual improvement.

1.2 Composition

- Four Non-Executive Members of NHS Orkney, including the Chair of the Area Partnership Forum (Employee Director)
- Four Orkney Islands Council (OIC) Elected Members, who are members of the IJB and/or the Orkney Health and Care Committee.
- Chief Executive, NHS Orkney
- Chair and vice-chair is appointed by the NHS Orkney Board.

IN ATTENDANCE

- Medical Director (lead officer for clinical governance).
- Director of Public Health.
- Director of Nursing, Midwifery, Allied Health Professionals & Acute Services.
- Director of Pharmacy.
- Chief Officer (lead officer for care governance)
- Chief Social Work Officer.
- Chief Quality Officer
- Public representative.

1.3 Meetings

The meeting will meet at least quarterly.

1.4 Quorum

Meetings of the Committee will be quorate when attendance consists of at least five members and at least:

- Two should be Non-Executive Members.
- One of whom is the Chair or Vice Chair.
- Two OIC Elected Member. two
- One who is a member of the IJB.

1.5 Remit

To provide NHS Orkney Health Board and the IJB, with assurance that robust governance, management systems and processes are in place and are effective throughout the whole system. This applies to health and care services provided by NHS Orkney, services provided by OIC and services commissioned by the IJB from other sources.

CLINICAL AND CARE RISK MANAGEMENT

To provide assurance regarding Adverse Event Reporting, Regulating Compliance, Risk Management, Significant Event Analysis (SEA) and Patient Safety and that there are adequate systems and processes in place across the whole system for health and care services provided by NHS Orkney, OIC and services commissioned by the IJB from other sources to ensure:

- Robust clinical and care control frameworks are in place for the effective management of clinical and care risk and that they are working effectively across the whole system.
- Clinical and care standards are not adversely impacted. through efficiency programmes.
- Adverse event management and reporting is in place and lessons are learnt from adverse events and near misses. Learning is applied across all relevant services.
- Data and measurement systems underpin the delivery of care and these are monitored through organisational performance review and reported to the Quality and Safety Group.
- Care delivery is supported by robust evidence based workforce and workload planning.
- Assurance of standards and quality of care.
- The Committee will receive an update at each meeting in relation to strategic risks aligned to the Committee.
- There is a clear escalation process in place for identified risks that cannot be mitigated.

CLINICAL, CARE AND PUBLIC HEALTH EFFECTIVENESS

To provide assurance regarding evidence-based practice, research and development, outcome measures, clinical and care audit and guidelines and that there are adequate systems and processes in place across the whole system of health and care services provided by NHS Orkney, OIC and services commissioned by the IJB from other sources to ensure**:**

- Highest quality of care and support is everyone’s responsibility.
- Compliance with national standards for quality and safety.

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- Where results of inspections of health and social care services are below required standards, appropriate action plans will be developed and monitored by the Quality and Safety Group and reported to the Committee.
- The Committee will receive reports on the effectiveness of controls in place to mitigate against clinical and care risks.
- Where the requirement for performance improvement is identified and evidenced by an appropriate individual or agency, the Committee will approve appropriate improvement intervention and seek assurance regarding the reliability of the improvement intervention.
- Unacceptable clinical and care practice where detected will be addressed.

PERSON CENTEREDNESS

To provide assurance regarding patient care and experience, quality and diversity, feedback, patient and client information, participation and communication and engagement.

- Feedback and complaints are handled in accordance with national guidance and lessons are learnt and improvements made from complaints investigations and their resolution. Improvements are also made from investigations undertaken by the Scottish Public Services Ombudsman (SPSO), Mental Welfare Commission (MWC), the Equality and Human Rights Commission (EHRC) and from legal proceedings against the Board and/or the IJB.
- To provide assurance that health and care services provided by NHS Orkney, OIC and services commissioned by the IJB from other sources are complying with the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 and to provide assurance that robust equality and diversity systems and processes are in place and effective throughout the NHS Orkney and Orkney Health and Care.
- Full account is taken of the perspective of patients and service users in shaping services and organisational practices.

CONTINUOUS IMPROVEMENT AND PROFESSIONAL STANDARDS

To provide assurance regarding Healthcare Improvement Scotland and Care Inspectorate collaborative, improvement programmes and professional standards and regulations and that there are adequate systems in place across health and social care in Orkney pertaining to:

- Staff Governance issues which impact on patient or client care, service delivery and quality of services are appropriately managed through clinical and care governance mechanisms and effective training and development is in place for all staff.
- Assurance is provided about training and education. The Committee will review and approve clinical policies.

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- Assurance is provided that staff are appropriately supported and developed within a culture of openness, learning and high performance.

1.6 Best Value

The Committee is responsible for reviewing those aspects of Best Value delegated to it from Orkney NHS Board and the IJB. The Committee will review and scrutinize the arrangements which are in place and will provide assurance to the Chief Executives (of NHS Orkney and of Orkney Islands Council), as accountable officers, that NHS Orkney and the IJB has systems and processes in place to secure best value. The assurance to the Chief Executives should be included as an explicit statement in the Committees Annual Report.

Authority

The Committee is accountable to NHS Orkney for clinical matters and is authorised by the Board of NHS Orkney and the IJB to investigate any activity within its Terms of Reference and in doing so, is authorised to seek any information it requires.

The Committee may obtain whatever professional advice it requires, and requires Directors or other officers of NHS Orkney, OIC, the Chief Officer of the IJB and Chief Social Work Officer to attend whole or part of any meetings.

The External Auditor and Chief Internal Auditor shall have the right of direct access to the Chair of the Clinical and Care Governance Committee.

Reporting Arrangements

The Clinical and Care Governance Committee reports to the Orkney NHS Board and the IJB.

Following a meeting of the Clinical and Care Governance Committee the approved minute of that meeting should be presented at the next NHS Orkney Board and the next IJB.

The Clinical and Care Governance Committee should annually, and within three months of the start of the financial year, provide a work plan detailing the work to be taken forward by the Clinical and Care Governance Committee.

The Clinical and Care Governance Committee will produce an annual report for presentation to Orkney NHS Board and the IJB. The Annual report will describe the outcomes from the Committee during the year and provide assurance to the Audit Committee of both Boards.

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NHS Orkney

OHAC orkney health and care

WORKING DRAFT

NHS Orkney Clinical and Care Governance Committee Draft Risks, Controls and Assurance Framework

Principle Objective	Sub Category	Principle Risks	Key Controls	Assurance on Controls	Gaps in Controls
Improve the delivery of safe, effective patient centred care and our services	Safe	Failure to prevent avoidable harm	Risk management group	Risk reporting to Governance Committees and Board	Vulnerable persons protection Lead Nurse must be addressed
			WIRG meetings	Learning from Clinical Incidents – reporting to CCGC via QSG	
			Significant adverse event reviews	Report to CCGC	
			Infection control committee - HAI	Report to Board	
		Failure to implement legislation and directives	Corporate services summary of CEL's	Compliance reporting via QSG	Co-ordinated scrutiny process
				CCGC	Centralised process for recording, disseminating and assuring implementation of SG and Health Directives
		Pharmacy?			
	Effective	Failure to deliver coordinated care for patients	EiC, CAIR Dashboard, **u**se of guidelines and best practice	Audit of CAIR Dashboard, Documentation Audit, AWI Audit, Learning from clinical incidents process	Programme of planned clinical audit with clear reporting structure
					Guideline review and implementation checking process

WORKING DRAFT

Principle Objective	Sub Category	Principle Risks	Key Controls	Assurance on Controls	Gaps in Controls
		Failure to deliver optimal outcomes for patients	Use of guidelines and best practice	Learning from clinical incidents process	Guideline review and implementation checking process
			Clinical audit	Participation in national clinical audits	Programme of planned clinical audit with clear reporting structure
		Screening programmes are not implemented fully	Review of KPIs for screening programmes	Annual report WIRG	
		Failure to address access issues	Key waiting times -? Triage for clinical element	Exception reporting List cleansing by clinical staff	Lack of an established process
		Failure to provide a forum for clinical engagement, patient safety, policy, scrutiny and quality assessment	ACF/AMC Hosp Sub/GP Sub NAMAC TRADAC	CCGC	Absence of a formal Quality and Safety Group which is currently being reconstituted
	Person centred	Failure to meet equality and diversity	Equality and diversity assessment of major service change	Annual Report to Board	
		Failure to provide positive patient experience	Implementation of Learning from Clinical Incidents Policy and national guidance for Duty of Candour and Complaints.	Annual Duty of Candour report Annual Patient Experience Report to Board and quarterly reporting to CCGC	
			? patient reported outcomes		

Principle Objective	Sub Category	Principle Risks	Key Controls	Assurance on Controls	Gaps in Controls
			Implementation of realistic medicine	Annual report to Board, RM KPI's	
			Weekly Incident Review Group		
		Failure to act on and learn from patient feedback and experience	Have systems in place to log complaints and feedback.	Quarterly report on complaints and feedback	
			Weekly meeting reviews all incidents	Quarterly report on lessons learnt and how learning has been applied across all services	
			Programme for review of learning from elsewhere including SPSO	Monthly review of SPSO reports and community of practice learning, shared with QSG.	
		Failure to provide up to date and accessible information	All published information has a set review date	Annual report on schedule of reviews and reasons if not completed.	Regular reviews of the content of the information
			All information has advice on it on how to get the information in alternative formats or languages.		Lack of a centralised quality assurance process
		Failure to engage in shared decision making with patients	Consent policy	Annual audit of compliance with consent policy.	Policy on implementation and scrutiny of Realistic Medicine principles
		Failure to involve service users in planning of services	Patient Public Reference Group	Chairs report on RoDs to CCGC	PPRG requires review to provide best possible involvement

Principle Objective	Sub Category	Principle Risks	Key Controls	Assurance on Controls	Gaps in Controls
			Patient involvement in service reviews	Service review KPI's	
			Citizen jury approach	Annual Duty of Candour report	Citizens Jury system not formalised locally
				Annual Patient Experience Report to Board and quarterly reporting to CCGC	
				CJ outcomes to CCGC via QSG	
Optimise the health gain for the population through the best use of resources;	Realistic medicine	Risks of inappropriate treatment	Review of Atlas of variation	Chairs reports from QSG presented to CCGC	Clinical Strategy not yet adopted
			Clinical Audit programme		Integration of Commissioning and Delivery strategies to be aligned
					Function of IJB SPG to be reviewed
		Failure to work in partnership	Regional working, once for Scotland	Regional working report to CCGC and Board	
		Failure to apply evidence based practice	Equality and diversity impact assessments	Annual Report on Equality and Diversity to Board	Resilience activity audit??
			NHS Business continuity plans mitigate loss of service	Annual Patient Experience Report to Board and quarterly reporting to CCGC	
Pioneer innovative ways of working to meet local health	Primary care	Failure to implement primary care improvement plan	Approved plan	Annual report to SG on progress	Requires to be resourced and managed appropriately

Principle Objective	Sub Category	Principle Risks	Key Controls	Assurance on Controls	Gaps in Controls
needs and reduce inequalities					in order to support implementation
		Failure to implement vaccination transformation plan	Approved plan	Annual report to SG on progress	Requires to be resourced and managed appropriately in order to support implementation
Create an environment of service excellence and continuous improvement;	Quality Improvement Approach	Failure to deliver improvement in service and patient outcomes	CQI delivery plan	Progress reported annually to Healthcare Improvement Scotland	
			Participation in national QI programmes	Part of national reporting and aligned with access target performance	
			Quality of Care Approach	Self assessment reporting and external review	Framework of quality of care measures agreed and reported through governance channels
Be trusted at every level of engagement.		Failure to maintain public trust	PPRG	Reporting on patient satisfaction	Comprehensive cross forum monitoring process for triangulation
			Consultation on key strategies and actions	Complaints procedures	
		Failure to maintain Staff Trust	HR Policies	APF	
			APF	Staff Groups (NAMAC, TRADAC)	
			I-Matter		
Integration Joint Board	Commissioning role	Failure to plan clinical services in	Health Strategy	IJB SPG	Integration of Commissioning and

Principle Objective	Sub Category	Principle Risks	Key Controls	Assurance on Controls	Gaps in Controls
		an integrated manner			Delivery strategies to be aligned
			Strategic Plan	Chairs reports on Advisory Groups QSG to CCGC	
			Strategic Commissioning Implementation Plan		
		Failure to improve health and wellbeing of those with drug and alcohol issues	ADP Strategy and action plan	ADP Strategy Group	
				ADP Commissioning Group	
				Reports to Integrated Joint Board	
	Social care		Staff supervision	Issues escalated where required through line management	A significant number of vacancies exist in frontline care posts with a reliance on agency staff at present.
			Unit Lead meeting		
			SWSC Governance Group		
			OHAC SMT		Significant gaps in senior structure
			OHAC/ELH Joint Directorate Meeting		
			Regulated Inspections	Presented to IJB within CSWO annual report.	
			Strategic Inspections	Reports to IJB, OIC and NHSO	

Principle Objective	Sub Category	Principle Risks	Key Controls	Assurance on Controls	Gaps in Controls
	Statutory Social Work Services	Failure to prevent avoidable harm	Staff supervision	PPC QA Sub Group	A number of key vacancies exist at service manager level within adult SW services
			Operational Managers Meeting	CSWO Report to CCG Committee	
		Failure to implement legislation and regulations	SWSC Governance Group	SW Governance Group	The current planning and performance post is subject to long term sickness, pending redesign.
			OHAC SMT	PPC	The current performance and planning manager is interim which risks ongoing dissemination and service planning activity
			OHAC/ELH Joint directorate meetings		
			Service Team Meetings		
			Staff Supervision		
		Failure to learn from service user experience / SCR's / examples of good practice from elsewhere	Joint meeting with CSWO/P and P Officer	CSWO Report to CCG	Current performance and planning post (who also investigates complaints) is subject to long term sickness.
			Reporting to OHAC/NHSO	CSWO Annual Report	Current independent chair of PPC is temporary
			SCR's on PPC Agenda	PPC via CPC and APC Workplans and Reports	A joint OHAC/NHSO suicide review protocol for care experienced young people (started)

Principle Objective	Sub Category	Principle Risks	Key Controls	Assurance on Controls	Gaps in Controls
				SW Governance Group	There are currently no independent reviewing officers
		Failure to provide a range of service to keep vulnerable people safe	Commissioning Programme Board	Executive Programme Board	No clear process at present to address such issues out with the budgetary process. This challenges the ability to respond quickly to acute situations.
			CSWO access to Chief Executive	CSWO report to CCG	
			HoS Supervision with PSW'ers and Service Manager (Public Protection)	CSWO annual report	
				SW Governance Group HoS Supervision with CO	