

Transforming Patient Safety and Quality of Care in NHS Lanarkshire

Quality Assurance and Improvement Framework

(companion document to strategy)

2014-17

Executive Lead:	Dr I. Wallace, Medical Director
Prepared by:	P. Milliken, Head of Clinical Governance and Risk Management
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1. Purpose

This is a companion document to the Transforming Patient Safety and Quality of Care in NHS Lanarkshire Strategy 2014-2017. It sets out the Board's Quality Assurance and Improvement Framework which ensures that NHS Lanarkshire has:

- A highly structured governance and accountability framework providing quality assurance from front line services to the Lanarkshire NHS Board
- Board Committees, Strategic and Operational Groups with clear and defined quality assurance and improvement and clinical governance roles and responsibilities
- Supports self-regulation enabling the Lanarkshire NHS Board, Healthcare Quality Assurance and Improvement Committee, Healthcare Quality Assurance and Improvement Steering Group and Equality, Diversity and Spirituality Steering Group to monitor and use performance, quality and safety data to identify issues that need to be addressed and take follow up action
- Links between quality assurance and improvement and clinical governance and NHS Lanarkshire's overall performance management

The scope of the of NHS Lanarkshire's Quality Assurance and Improvement framework covers all acute, community and managed primary care services. Independent contractors have responsibilities in relation to the quality assurance and improvement of the care they provide and to work closely with NHS Board's clinical governance structures.

In relation to General Practitioners, PCA(M)(2010)18, Clinical and Staff Governance for General Practice in Scotland, 2010 sets out legal and contractual requirements in relation to clinical governance as well as professional and aspirational good practice. Prescription for Excellence: A Vision and Action Plan, 2013 states that "pharmacists that will be delivering the pharmaceutical care in the community will need to ensure that when they manage patients, they work with medical and nursing colleagues to implement clinical guidance and undertake the relevant monitoring where appropriate. They will need to ensure they work closely with the NHS Board's governance structure for utilisation of medicines."

Patient and families care span health and social care and partnership working is already in place operationally. However, the healthcare quality assurance and improvement strategy and framework will need to change with implementation of Health and Social Care Partnerships. The Scottish Government has established a Clinical and Care Governance Working Group which is taking into consideration existing arrangements in order to develop guidance for clinical and care governance arrangements to support the integration of health and social care. It is understood that this guidance will be published in December 2014. In advance of this guidance, NHS Lanarkshire has developed a map of current healthcare quality assurance and improvement arrangements and shared this with both North Lanarkshire and South Lanarkshire Councils.

2. Definition of Quality Assurance and Improvement and Clinical Governance

The Healthcare Quality Strategy for NHSScotland defines quality as being about:

"Putting people at the heart of our NHS. It will mean that our NHS will listen to peoples' views, gather information about their perceptions and personal experience of care and use that information to further improve care.

Building on the values of the people working in and with NHSScotland and their commitment to providing the best possible care and advice compassionately and reliably by making the right thing easier to do for every person, every time.

Making measurable improvement in the aspects of quality of care that patients, their families and carers and those providing healthcare services see as really important.”

Clinical Governance provides organisations with an assurance in relation to quality and risk. The definition of clinical governance utilised by NHS Quality Improvement Scotland (2005)¹ is:

A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

(Scally and Donaldson, 1998)

NHS Lanarkshire has recognised that front line staff do not understand the terminology “Clinical Governance” and consequently the use of this term does not support their engagement in this area. Hence NHS Lanarkshire uses instead the term “Quality Assurance and Improvement”. The terminology of Quality Assurance and Improvement is used throughout NHS Lanarkshire’s Transforming Patient Safety and Quality of Care in NHS Lanarkshire Strategy 2014-2017.

3. National Context

The national context for quality assurance, improvement and clinical governance is set by:

- A promise to learn - a commitment to act. Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England, 2013
- The 3-Step Improvement Framework for Scotland’s Public Services, Scottish Government, 2013 Quality governance:
- How does a board know that its organisation is working effectively to improve patient care, Monitor, 2013
- The Healthcare Quality Strategy for NHS Scotland (2010)
- NHS Healthcare Improvement Scotland (formally QIS) Standards on Clinical Governance and Risk Management
- Scottish Government Health Department draft policy paper “Future Approach to Governance, 2010”
- NHS Scotland Framework for Developing Boards, Board Diagnostic Tool, 2010
- NHS Scotland Efficiency and Productivity: Framework for SR10, 2011-2015
- Equality Act, 2010
- Scottish Executive MEL (1998) 75 Clinical Governance and Scottish Executive MEL (2000) 29 Clinical Governance

In particular, *A promise to learn - a commitment to act. Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England, 2013* sets out ten specific recommendations which NHS Lanarkshire has sought to support through this framework and our strategy:

1. The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.

¹ NHS QIS (2005) Clinical Governance and Patient Safety Support Unit, Work Programme 2005-2007

2. All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.
3. Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.
4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.
5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives.
6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.
7. Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.
8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.
10. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.

4. Quality Assurance and Improvement Strategy – Local Context

The Transforming Patient Safety and Quality of Care in NHS Lanarkshire Strategy 2014-2017 sets out the following local context (in sections of the document) for the Quality Assurance and Improvement Framework:

Section 5 – Ensure accountability for quality

This section sets out the following's responsibilities for the Quality Assurance and Improvement Framework:

- The Board and Board Members
- Chief Executive
- All staff
- Leaders and managers
- Healthcare Quality Assurance and Improvement Committee
- Healthcare Quality Assurance and Improvement Steering Group
- Care Assurance Board

All individuals and teams are responsible for putting quality assurance and improvement into practice. This responsibility is demonstrated through:

- Professional Codes of Practice
- Continuous professional development
- Appraisal
- Revalidation
- Improvement activity and measurement

- Audit
- Evidence Based Practice
- Personal Reflection
- Learning from adverse events, complaints and feedback.

5. Quality Assurance and Improvement Framework

The quality assurance and improvement framework includes:

- The Quality Assurance and Improvement Strategy (see section 4 above)
- An annual work programme and annual report
- Roles and responsibilities for quality assurance and improvement
- Quality assurance and improvement structure and processes, monitoring and reporting arrangements
- The annual governance statement.

ANNUAL WORK PROGRAMME AND ANNUAL REPORT

Each year NHS Lanarkshire sets out a prioritised, achievable and sustainable work programme of initiatives to support the delivery of the Quality Assurance and Improvement Strategy and quality goals.

NHS Lanarkshire produces a Quality Assurance and Improvement Annual Report as part of the support for the annual governance statement. The Annual Report provides assurance to the people of Lanarkshire about our quality of care and to share good practice and learning throughout the organisation.

ROLES AND RESPONSIBILITIES

NHS Mel (2000)29, circular refers to addressing quality assurance and improvement (clinical governance) at four levels, these being a practicing role, a supporting role, a delivering role and an overseeing role. Reflecting this NHS Lanarkshire's structure is shown in Table 1 below.

It should be noted that information governance in NHS Lanarkshire, including clinical information governance, is the responsibility of Director of Public Health (Caldicott) and IM&T. Clinical risk management is the responsibility of the Medical Director with non-clinical risks reporting into the Director of Finance, Director of Human Resources and the Director of Planning and Performance.

Table 1: Levels of Quality Assurance and Improvement and Roles

Levels	Roles	Leads	Groups	Achieved by
Teams, Individuals	Putting quality assurance and improvement into practice	All clinical and support staff	Wards, Teams, Departments, Services	<ul style="list-style-type: none"> • Professional Codes of Practice • CPD • Improvement activity • Audit • Evidence Based Practice • Personal Reflection
Support Departments	Providing the Quality Assurance	Safety and Quality Clinical Leads Head of CG&RM	Clinical Governance and Risk Management Department (Clinical	<ul style="list-style-type: none"> • Providing the Quality Assurance and Improvement and

Levels	Roles	Leads	Groups	Achieved by
	and Improvement and Clinical Risk Management Frameworks and supporting quality assurance and improvement and clinical risk management	Director of NMAHPs Practice Development Corporate Clinical Quality Manager Corporate Risk Manager Head of Patient Safety and Improvement Corporate Research and Development Manager Head of Patient Affairs Head of Organisational Development	Quality, Patient Safety, Risk Management and Research and Development) Patient Affairs Department Practice Development Centre Practice Development Nursing Team for Mental Health Organisational Development Communications Department IMT Department	<p>Clinical Risk Management Frameworks</p> <ul style="list-style-type: none"> • Providing mechanisms to measure and report on quality assurance and improvement • Providing development support and advice to all levels in organisation on clinical quality, research and development, patient safety, clinical risk management, patient feedback
Management Boards, Groups and Teams	Delivering the Quality Assurance and Improvement and Clinical Risk Management Frameworks	Divisional Medical Directors Divisional Nursing Directors Associate Director of AHPs Director of NMAHPs Practice Development Associate Medical Directors and Associate Nursing Directors / Chief of Medical Services and Chief of Nursing Services General Managers / Director of Hospital Services Clinical Directors MCN Clinical Leads GP Leads Senior Nurses Service Managers Partnership	Acute DMT and CHP Operating Committees Joint CHP Clinical Governance and Risk Management Committee and sub groups Acute Clinical Governance and Risk Management Committee and sub groups Care Assurance Board Senior NMAHPs Group for Nursing, Midwifery, Allied Health Professionals and their Support Pan Lanarkshire Quality Assurance and Improvement Groups (e.g. Blood Transfusion Committee, Area Drugs and Therapeutic Committee) Managed Clinical Networks	<ul style="list-style-type: none"> • Establish, support, operate and monitor systems to deliver to Quality Assurance and Improvement
NHS Lanarkshire Wide Governance and Advisory	Overseeing the Quality Assurance and Improvement	Non Executives Chief Executive Medical Director Director of NMAHPs Director of Public	Healthcare Quality Assurance and Improvement Committee Healthcare Quality Assurance and	<ul style="list-style-type: none"> • Review the Quality Assurance and Improvement and Clinical Risk Management

Levels	Roles	Leads	Groups	Achieved by
	Frameworks and gaining assurance on quality assurance and improvement	Health Other Executive Directors Chair Area Clinical Forum Chair Area Partnership Forum	Improvement Steering Group Care Assurance Board Information Assurance Committee Area Clinical Forum and Professional Advisory Committees	<p>Frameworks to ensure they are fit for purpose</p> <ul style="list-style-type: none"> • Provide assurance to the NHS Lanarkshire Board on quality assurance and improvement and clinical risk management • Act as guardians of the quality assurance, improvement and quality assurance and improvement. Hold the organisation to account through effective scrutiny, constructive challenge, strengthened assurance and accountability.

There is an absolute recognition that patient safety and quality is everyone’s responsibility, and that every single member of staff in NHS Lanarkshire has their part to play.

Clinical Leads

All clinical leads are responsible for promoting high standards of patient safety and quality of care and development of clinical practice as well as providing professional advice and leadership to other healthcare professionals. This includes offering advice about current clinical practice, quality, safety, and being an active member of quality assurance, quality improvement and clinical risk management groups.

Leaders and Managers

Leaders and managers in all areas have particular responsibility as role models and enablers in the promotion of safety, quality and a fair and just culture and must demonstrate this through their everyday actions and behaviours.

All managers are responsible for effective patient safety, quality assurance and improvement and clinical risk management within their own area. NHS Lanarkshire has an established framework for quality assurance and improvement and risk management and all line managers must be committed to implementing these. They own these processes and take action, both proactively and reactively, in relation to standards of patient safety and quality, workforce development, clinical risk management and dealing with patient feedback. In addition they ensure a high quality service to patients by the continual development of practice according to research evidence and national standards.

Staff

All staff have a responsibility for patient safety and quality by initiating remedial actions in response to patient safety and quality concerns, suggesting and implementing improvements to services and in exercising professional responsibility for both themselves and their peers within an open, just and fair culture.

Departments and functions

A number of departments and functions support patient safety, quality assurance and improvement and clinical risk management.

The Clinical Governance and Risk Management Department designs the quality assurance and improvement and risk management frameworks and includes the functions:

Clinical Quality works closely with clinical staff and management to support improvements in quality of patient care against best practice, standards and in response to clinical quality issues that are raised by external bodies. The service supports measurement for improvement; however there is an intention that the function will increasingly support the application of improvement methodology. Support is also provided for Board quality assurance information, measurement for NHS Lanarkshire's Local Harm Free Collaborative and Hospital Associated Infections, audits, all Health Improvement Scotland reviews, dissemination and monitoring of implementation of clinical standards, guidelines, best practice statements and patient safety alerts.

Risk Management enables an infrastructure and culture for the Board and operational teams to manage corporate and clinical risk effectively and efficiently that allows continuous improvement in decision-making whilst improving performance. This is undertaken through the risk management framework including:

- Risk management strategy and work plan
- Universal risk assessment
- Systems and guidance to enable recording of all adverse events and sharing of learning
- Strategic, operational, service and project specific risk registers with a clear escalation process.

Research and Development works with NHS Lanarkshire staff to advise on study design, ethics application and consent processes, providing training in areas such as abstract writing, poster design, literature review. Ensure governance review of research studies and robust financial management.

Patient Safety leads the development, implementation support and monitoring of NHS Lanarkshire's Patient Safety Strategic Prioritised Plan. This encompasses: a Local Harm Reduction Collaborative, national programmes of work as well as locally determined work streams and activities based on the identification of the boards local patient safety priorities.

Other functions include:

Patient Affairs function which is responsible for the patient experience, complaints and claims and ensures that patient feedback drives quality assurance and improvement. It also supports the local implementation of the Person Centred Care Collaborative.

Nursing, Midwife, Allied Health Professional (NMAHP) Practice Development Centre delivers a service concerned with the continuous improvement and quality assurance of patient care by providing professional leadership, facilitation and learning support, working with NMAHP practitioners at all levels within NHS Lanarkshire.

The Department of Medical Education supports training for medical undergraduates, postgraduate trainees and senior medical staff. It contributes to quality control and performs against key standards for all levels and

specialties of postgraduate medical education training. Medical education also strives to support senior staff in the requirements stipulated by Colleges and other national bodies for continuous professional development.

QUALITY ASSURANCE AND IMPROVEMENT STRUCTURE

The following main groups provide a structure to ensure the delivery of the clinical governance and clinical risk management framework. The terms of reference of these groups are provided in Appendix 1.

Board

As set out in the Code of Corporate Governance, 2014, the overall purpose of the Lanarkshire NHS Board is to ensure the efficient, effective and accountable governance of the NHS Lanarkshire health system, and to provide strategic leadership and direction for the system as a whole, focusing on agreed outcomes.

Board Healthcare Quality Assurance and Improvement Committee

The Healthcare Quality Assurance and Improvement Committee is the Committee of the Board which supports the Board in its responsibilities for issues of clinical risk, control and governance and associated assurance in the area of quality assurance and improvement through a process of constructive challenge. The Committee's purpose is set within a context for the overall implementation of the 20:20 Vision for the NHS in Scotland and the associated Route Map.

The Committee is responsible for the development of a strategic approach to quality assurance and improvement across the organization, ensuring that quality standards are being set, met and continuously improved for clinical activity. It also ensures that effective arrangements for supporting, monitoring and reporting on quality assurance and improvement are in place and working, demonstrating compliance with statutory requirements in relation to clinical governance and authorising an accurate and honest annual clinical governance statement. The Healthcare Quality Assurance and Improvement Committee seeks assurance in relation to these arrangements from the Healthcare Quality Assurance and Improvement Steering Group. The Healthcare Quality Assurance and Improvement Committee considers the Corporate Quality Assurance and Improvement Dashboard seeking assurance and considering areas of risk to quality of healthcare.

Board Healthcare Quality Assurance and Improvement Steering Group

The Healthcare Quality Assurance and Improvement Steering Group supports the NHS Lanarkshire Healthcare Quality Assurance and Improvement Committee to ensure that the quality assurance and improvement framework is in place and operating, directing the annual quality assurance and improvement work schedule and receiving assurance from the service of its implementation. The Healthcare Quality Assurance and Improvement Steering Group ratifies pan Lanarkshire clinical policies.

Care Assurance Board

Care Assurance Board provides an overarching care assurance system which promotes the provision of a culture where care is consistently person-centred, clinically effective and safe, for every person, every time, and where caring behaviours will have at their heart the NHS Lanarkshire organisational values of fairness, respect, working together and quality.

The Care Assurance Board receives information, updates and reports from the sources below and proactively anticipates/acts on care governance issues, ensuring that causal links are made and organisational learning opportunities are recognised and shared. It explores themes and trends and directs improvement activities to ensure the spread of best practice.

- Acute ward dashboard/mental health Scottish Recovery Index/Community dashboard
- Care environment observations
- Patient Experience Indicators
- Leading Better Care
- Volunteering

- Older People in Acute Hospitals work
- Learning from feedback, comments, concerns and complaints
- Datix reports
- Any actions arising from the Francis Inquiry Report specific to this area.

Board Risk Management Steering Group

The Risk Management Steering Group supports the NHS Lanarkshire Healthcare Quality Assurance and Improvement Committee in relation to clinical risk management by providing a strategic approach to proactive risk management across NHS Lanarkshire through on-going identification, assessment and management of clinical risks, with the expectation that this will improve the quality of services, the working environment and reduce the incidence of injuries, material damage or loss. The Risk Management Steering Group oversees the Risk Management Strategy, Framework and the annual risk management work programme.

Clinical risks are overseen through the Operational Divisions' Risk Registers and each year the Operating Divisions' Risk Registers are reviewed by the Risk Management Steering Group. The Risk Management Steering Group reviews the Strategic Risk Register and considers emerging risks. The Risk Management Steering Group considers a report at every meeting on risks which are out of date or meet a tolerance criteria (those risks which are assessed as very high with an assessed adequacy of control as either inadequate or uncertain). If this tolerance criteria is met then an assurance report is required.

Joint Community Health Partnership² Clinical Governance and Risk Management Committee and Acute Clinical Governance and Risk Management Committee

The Joint CHP Clinical Governance and Risk Management Committee and Acute Clinical Governance and Risk Management Committee, which are chaired by the Medical Directors for Primary Care and Acute respectively, are accountable to the NHS Lanarkshire Healthcare Quality Assurance and Improvement Steering Group. The remit of these committees is to reassure NHS Lanarkshire on quality assurance and improvement and clinical risk management and monitor and prioritise activity for the CHPs and Acute Division. These committees are supported by a range of groups which will ensure actions in relation to quality assurance and improvement and clinical risk management are progressed and practice is reviewed across primary and acute care. The Joint CHP Clinical Governance and Risk Management Committee and Acute Clinical Governance and Risk Management Committee ratifies primary care and acute clinical policies respectively.

Community Health Partnerships and Acute Divisional Management Teams

The CHP and Acute Divisional Management Teams are responsible for the quality and safety of operational services. These teams ensure that systems are in place to support quality assurance and improvement and the implementation of quality assurance and improvement and clinical risk management structures and processes.

ANNUAL GOVERNANCE STATEMENT

The annual governance statement, for which the Board's Accountable Officer takes personal responsibility, is a key feature of NHS Lanarkshire's annual report and accounts. It covers the accounting period and provides the Scottish Government and public with a clear understanding of the organisation's internal control structure and its management of resources. The statement is informed by work undertaken throughout the period to gain assurance about performance and risk management, provides an insight into the organisation's risk profile and its responses to identified and emerging risks.

The Chair of the Healthcare Quality Assurance and Improvement Committee provides the element of the annual governance statement relating to clinical governance and information governance. This statement is informed by a Key Lines of Enquiry document and the Quality Assurance and Improvement Annual Report.

² The Clinical Governance arrangements for the CHPs will be reviewed as part integration into Health and Care Partnerships. This is being scoped with during 2014/15.

6. Internal and External Review

Internal review is undertaken through the annual report and governance statement. The Healthcare Quality Assurance and Improvement Committee, in line with all NHS Lanarkshire Committees of the Board, reviews its functioning on an annual basis.

NHS Lanarkshire's Audit Committee monitors the effectiveness of the systems of internal control by commissioning internal audits and reviews and the monitoring of response to any action plans arising from the reports. This includes reviews of quality assurance, quality improvement and clinical governance.

NHS Lanarkshire participates in external inspections and reviews undertaken by NHS Healthcare Improvement Scotland (including the Mental Welfare Commission) and other bodies (e.g. Care Inspectorate). NHS Lanarkshire produces action plans in response to inspections and reviews and quality assurance and improvement groups monitor the implementation of these actions.

7. References

A promise to learn - a commitment to act. Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England, 2013

Audit Scotland (2008) Priorities and Risk Framework, A national planning tool for 2008/09 NHS Scotland audits

Equality Act, 2010

High performing healthcare organisations: A brief introduction, Healthcare Improvement Scotland, 2013

NHS Quality Improvement Scotland (NHS QIS) Standards for Clinical Governance and Risk Management (October 2005)

PCA(M)(2010)18, Clinical and Staff Governance for General Practice in Scotland, 2010

Prescription for Excellence: A Vision and Action Plan, Scottish Government, 2013

Scottish Executive MEL (1998) 75 Clinical Governance

Scottish Executive MEL (2000) 29 Clinical Governance

Scottish Executive (2003) Partnership for Care – Scotland's Health White Paper

Scottish Government Health Department (2008) Leading Better Care: Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project

Scottish Government (2010), The Healthcare Quality Strategy for NHS Scotland

Scottish Government Health Department (2010) draft policy paper Future Approach to Governance

Taking safety on board: the board's role in patient safety, Health Foundation, 2013



APPENDIX 1 – TERMS OF REFERENCE OF QUALITY ASSURANCE AND IMPROVEMENT GROUPS

LANARKSHIRE NHS BOARD COMMITTEE TERMS OF REFERENCE

COMMITTEE: Healthcare Quality Assurance and Improvement Committee
DATE: June 2014

1. Purpose

The Board has established a Healthcare Quality Assurance and Improvement Committee as a Committee of the Board to support the Board in its responsibilities for issues of risk, control and governance and associated assurance in the area of Clinical Governance, through a process of constructive challenge. The Committee's purpose will be set within a context for the overall implementation of the 20:20 Vision for the NHS in Scotland and the associated Route Map.

NHS Lanarkshire's quality vision is to achieve transformational improvement in the provision of safe, person-centred and effective care for patients, and for patients to be confident that this is what they will receive, no matter where and when they access services.

To achieve our quality vision, the Board is committed to transforming the quality of health care in Lanarkshire through investment in and continuous reliable implementation of patient safety processes. Through this, the Board aims to:

- ▶ be the safest health and care system in Scotland
- ▶ have no avoidable deaths
- ▶ reduce avoidable harm
- ▶ deliver care in partnership with patients that is responsive to their needs
- ▶ meet the highest standards of evidence based best practice
- ▶ be an employer of choice
- ▶ develop a culture of learning and improvement, characterised by our values of Fairness, Respect, Quality and Working Together
- ▶ ensure equity of access so that all individuals, whatever their background, achieve the maximum benefit from services and interventions provided, within available resources

The Healthcare Quality Assurance and Improvement Committee is responsible for providing assurance

at all levels across the organisation that the health improvement and care we provide fulfils the Quality Ambitions of being Safe, Effective and Person-Centred and that staff at all levels, are given the necessary support to identify areas for quality improvement and the training and development to implement change. Or, as the Berwick Review³ eloquently put it;

"Place the quality of patient care, especially patient safety, above all other aims. Engage, empower, and hear patients and carers at all times.

Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge"

2. Membership & Quoracy

Membership of the Healthcare Quality Assurance and Improvement Committee will be drawn from the Non-Executive Director component of the NHS Board. There will be 6 Non-Executive Director Members of the Healthcare Quality Assurance and Improvement Committee, one of whom will be the Chair of the Area Clinical Forum. One of the Non-Executive Director Members will be designated as Chair of the Committee. The appointment of the Chair of the Committee will be decided by the NHS Board Chair, in discussion with Non-Executive Directors about the assignment of Committee portfolios.

To be quorate, meetings will require the attendance of two Non-Executive Director Members. In the absence of the designated Chair, the remaining Members will appoint a Chair from amongst their number. Although not a requirement for Quoracy, it is expected that one of the following Executive Directors will be in attendance at Meetings, viz: the Medical Director; the Director for Nurses, Midwives and the Allied Health Professions; the Director of Public Health and Health Policy.

3. Reporting Arrangements

The Healthcare Quality Assurance and Improvement Committee will report to the NHS Board following each meeting. This will be through a verbal report or a written Summary Report on the key issues considered by the Committee, and by the submission of minutes of meetings to the NHS Board.

The Committee will prepare an Action Log that will be monitored and updated at each subsequent meeting.

The Committee will conduct a mid-year review of progress against the annual Work Programme, as part of the process to ensure that the Work Programme is delivered. This mid-year review will be aligned to the Committee Terms of Reference.

In accordance with Best Value for NHS Board and Committee working, the Committee will submit to the NHS Board in May an Annual Report, encompassing: the name of the Committee; the Committee

³ *A promise to learn - a commitment to act. Improving the Safety of Patients in England. National Advisory Group on the Safety of Patients in England. 2013*

Chair; Members; the Executive Lead and officer supports/attendees; frequency and dates of meetings; the activities of the Committee during the year, including confirmation of delivery of the Work Programme, and review of the Committee Terms of Reference; improvements overseen by the Committee; matters of concern to the Committee; confirmation that the Committee has fulfilled its remit, and confirmation of the adequacy and effectiveness of the Healthcare Quality Assurance and Improvement arrangements in NHS Lanarkshire.

The Committee Annual report will inform the submission of any appropriate assurance to the Chief Executive at the year-end, as part of the Governance Statement.

Where the review by the Committee of its Terms of Reference results in amendment, the revised Terms of Reference must be submitted to the NHS Board for approval.

4. Key Responsibilities

To provide systems of assurance that healthcare quality assurance and improvement mechanisms including those relating to clinical risk management are in place and effective throughout NHS Lanarkshire. This remit includes:

- Endorsing the quality assurance and quality improvement strategy prior to approval from the NHS Board
- Bringing to the attention of the Lanarkshire NHS Board regular reports on the operation of the system, and specific reports on any problems that emerge and necessary corrective actions being taken
- Ensuring leadership, strategic direction and implementation of quality improvement as well as demonstrating its impact
- Ensuring equity in the provision of care, treatment and access to services, which incorporates the diverse needs of individuals and population sub-groups, and is appropriate and sensitive to the delivery of person-centred care
- As appropriate, critically reviewing reports and action plans arising from the work of internal audit, external audit, review agencies and inspectorates, as they relate to assurance on the effectiveness of clinical risk management and quality improvement
- Ensuring that recommendations made by the Scottish Public Services Ombudsman are implemented, including those recommendations applicable to independent practitioners
- Providing oversight on, behalf of the Board, of key governance groups and arrangements responsible for compliance with the Scottish Government Health and Social Care Directorate's directions, including Care Assurance Board, Infection Control Committee, Information Assurance, Equality and Diversity, Contract Monitoring Group, Research and Development arrangements, Public Health arrangements, Public Protection arrangements, Organ Donation and Local Supervisory Authority arrangements for midwives
- Ensure Public Health Governance in relation to health protection, health inequalities, health improvement and screening programmes and risk management including emergency plans and business continuity

- Consider how populations are served by and benefit from specific services and interventions; particularly whether some population sub-groups might experience service gaps or barriers to access
- Being assured that NHS Lanarkshire has in place a managed system for clinical policies.
- Ensuring the Healthcare Quality Assurance and Improvement Committee discharges its role in relation to Assuring Best Value.

5. Conduct of Business

Meetings

The Healthcare Quality Assurance and Improvement Committee will meet at least 6 times a year. The Chair of the Committee may convene additional meetings as he/she deems necessary.

Quorum (to be read with Section 2)

In the event of a meeting becoming inquorate once convened, the Chair may elect to continue to receive papers and presentations from those attending, as described in the agenda for the meeting, and to allow the Members present the opportunity to ask questions. The minute of the meeting will clearly state the point at which the meeting became inquorate, but notes of the presentation and discussion will be included with the Minute. Every item discussed once the meeting became inquorate will be brought back in summary from matters arising to the next meeting, and ratified, as appropriate.

Absence of Chair

In the event of the designated Chair of the Healthcare Quality Assurance and Improvement Committee being unable to attend, another member of the Committee will be designated by the Chair for the meeting. Normally, the Chair of the Committee will arrange this in advance.

Agenda and Papers

Agenda for meetings of the Committee will be formulated having regard to: Matters Arising from the previous meeting; the Committee Work Programme and reporting schedule; and the Committee Terms of Reference. The agenda will be agreed at an agenda-setting meeting involving the Medical Director and the Chair of the Committee, with other officer input, as appropriate. Agenda papers, should be submitted to the Board Secretary, or other designated officer(s) in sufficient time to enable the agenda and papers for meetings to be issued not later than one week before meetings of the Committee.

Minutes

A draft minute of each meeting of the Committee, formatted to clearly highlight key decisions, actions and risk management, should be produced and should be available to the Chair of the Committee and

the Medical Director for consideration within three weeks of the meeting date. Once agreed with the Chair of the Committee and the Medical Director, the minute will be submitted to the next scheduled meeting of the NHS Board for information. Prior to that, the key issues considered by the Committee will, as appropriate, be the subject of reporting to the NHS Board, either verbally or through the submission of a Summary Report. Minutes of meetings of the Committee do not need to be approved by the Committee prior to their submission to the NHS Board for information. Agendas and papers for meetings of the Committee will, routinely, be uploaded to the relevant 'Meetings' section on FirstPort.

Annual Work Programme

An Annual Work Programme, in fulfilment of the Committee's responsibility for oversight of the Quality Assurance and Improvement Strategy, and delivery of the Committee's Terms of Reference, will be agreed by the Committee in April, and submitted to the NHS Board for endorsement in June.

Mid Year Review

The Committee will conduct a mid-year review of progress in the delivery of the Annual Work Programme and reporting schedule. This mid-year review will also be aligned to the Committee's Terms of Reference. Indicatively, the mid-year review will be undertaken by the Committee at its meeting in October, with the outcome being reported to the NHS Board in November.

Annual Report

The Committee will submit to the NHS Board in May, an Annual Report, encompassing the name of the Committee; the Committee Chair; members; the Executive Lead and Officer supports/attendees; frequency and dates of meetings; the activities of the Committee during the year, including confirmation of delivery of the Work Programme, and review of the Committee Terms of Reference; Improvements overseen by the Committee; Matters of Concern to the Committee; Confirmation that the Committee has fulfilled its remit and confirmation of the adequacy and effectiveness of Healthcare Quality Assurance and Improvement arrangements within NHS Lanarkshire.

Action Log

An Action Log, setting out the key actions agreed at each meeting of the Committee will be produced, and agreed with the Committee Chair and the Medical Director. The Medical Director, with officer support provided by the Head of Clinical Governance and Risk Management and the Board Secretary, will ensure that actions are followed through timeously to completion. Updated action logs will be provided to each meeting of the Committee.

The Healthcare Quality Assurance and Improvement Committee may ask any or all of those who normally attend but who are not Members to withdraw to facilitate open and frank discussion on particular items.

The NHS Board or the Accountable Officer may ask the Healthcare Quality Assurance and improvement Committee to consider particular issues on which they wish the Committee's advice.

6. Information Requirements

The Committee will consider information, as appropriate, in order to fulfil its remit and deliver its work programme. This will include:

- a) Consistent, focussed data and risk driven Performance Management Reports.
- b) Triangulated data on feedback and complaints, staff feedback, quality, analysis of incidents and critical incidents, and operational performance data.
- c) Additional information and requirements that may arise and be required in year, in order to enable the Committee to properly fulfil its purpose.

Work Programme and Reporting Schedule

The Committee will oversee an annual work programme to progress the Board's Quality Assurance and Improvement Strategy, and a reporting schedule to provide assurance to the Committee. This reporting schedule will include (in line with the Quality Ambitions):

Safe Care

- Patient safety reports
- Reports on Serious Adverse Events (SAEs) and Serious Adverse Event Reviews (SAERs)
 - Live register of SAEs and SAERs with reporting of recommendations and date actions complete
- High level breakdown of adverse events with run chart
- Clinical extract of Corporate Risk Register
- Healthcare associated infection reports

Person Centred Care

- Patient experience and complaints report
- Patient stories

Effective Care

- Corporate Healthcare Quality Assurance and Improvement Dashboard Report
- National and local reports highlighting areas of good practice and areas for improvement
- Healthcare Improvement Scotland Inspections and Reviews
- Other review bodies reports
- Reports that provide assurance or identify areas of risk in relation to how specific services and interventions provide for their target population

Quality Infrastructure

- Quality Assurance and Improvement Work Programme, Mid-year Review and Annual Report

- Annual Reports:
 - Local Supervisory Authority Midwifery Annual Report
 - Public Protection Annual Report
 - Patient Affairs Annual Report
 - Governance Statement (Clinical element) and annual review of functioning of the Committee (Key Lines of Enquiry)
 - Healthcare Associated Infection Annual Report
 - Risk Management Annual Report
 - Equality and Diversity Annual Report
 - Volunteering Annual Report
 - Research and Development Annual Report (CSO)
- Reporting groups' minutes / reports:
 - Healthcare Quality Assurance and Improvement Steering Group
 - Acute and Joint CHP Clinical Governance and Risk Management Committees
 - Risk Management Steering Group
 - Contracts Monitoring Group
 - Information Assurance Committee
 - Equality and Diversity Steering Group
 - Care Assurance Board
 - Report confirming corporate clinical policy management

7. Executive Support and Attendance

Executive Lead :

Medical Director

Other Executive Support :

Director for Nurses, Midwives and the Allied Health Professions

Director of Public Health and Health Policy

Other Attendees :

NHS Board Chair

Chief Executive

Director of Human Resources

Head of Clinical Governance and Risk Management

Corporate Risk Manager

Divisional Medical Director, Acute Services

Associate Medical Director, Primary Care

Head of Patient Safety and Improvement

Staff Partnership Representative

Expert External Attendees :

Andy Crawford, Head of Clinical Governance, NHS Greater Glasgow and Clyde

Kevin Rooney, Professor of Care Improvement, University of the West of Scotland

Executive Director Lead

The designated Executive Lead will support the Chair of the Healthcare Quality Assurance and Improvement Committee in ensuring that the Committee operates according to/in fulfillment of, its agreed Terms of Reference. Specifically, they will:

- Support the Chair in ensuring that the Committee Remit is based on the latest guidance and relevant legislation, and the Board's Best Value framework;
- Liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;
- Oversee the development of an Annual Work Programme for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for endorsement by the Committee and approval by the NHS Board;
- Agree with the Chair an agenda for each meeting, having regard to the Committee's Remit and Work Programme;
- Lead a mid-year review of the Committee Terms of Reference and progress against the Annual Work Programme, as part of the process to ensure that the Work Programme is fulfilled;
- Oversee the production of an Annual Report on the delivery of the Committee's Remit and Work Programme, for endorsement by the Committee and submission to the NHS Board.

8. Access

The designated Chief Internal Auditor and the representative of External Audit will have free and confidential access to the Chair of the Healthcare Quality Assurance and Improvement Committee.

9. Rights

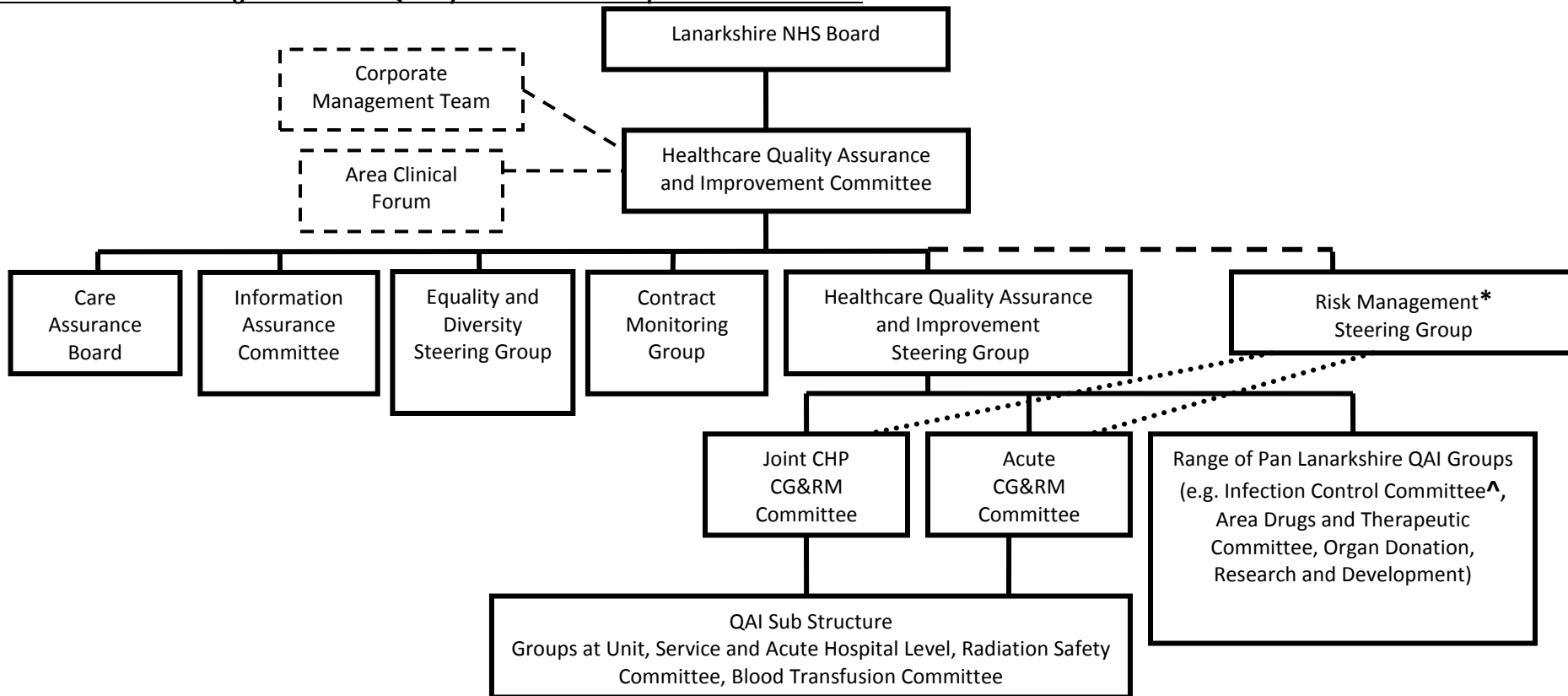
The Healthcare Quality Assurance and Improvement Committee may approve adhoc advice at the expense of the organization, subject to budgets agreed by the NHS Board or the Accountable Officer.

10. Review of Terms of Reference

The Healthcare Quality Assurance and Improvement Committee will review its Terms of Reference annually. As a minimum, the Terms of Reference will be updated to reflect the Reporting Schedule for the coming year.

Ratified by:	Lanarkshire NHS Board
Reviewed by Committee:	Agreed by Committee on 12 th June 2014
Ratified by NHS Board:	27 th August 2014
Authors:	Pamela Milliken, Head of Clinical Governance and Risk Management, and Neil Agnew, Board Secretary
Review date:	April 2015

NHS Lanarkshire Strategic Healthcare Quality Assurance and Improvement Structure



KEY:



Reports to

Informs and informed by

Reports risk issues via Acute Divisional and CHP Management Teams

*

Risk Management Steering Group reports into the Audit Committee and informs the HQAIC on clinical risks

^

Lanarkshire Infection Control Committee also reports into the Area Control of Communicable Diseases Committee

Healthcare Quality Assurance and Improvement Steering Group

Terms of Reference

Purpose:

To provide oversight and co-ordination of all aspects of Healthcare Quality Assurance and Improvement thereby supporting the role of the Healthcare Quality Assurance and Improvement Committee in assuring the Board that adequate healthcare governance systems and processes are in place across all services in line with the assurance, accountability and reporting framework described in *Transforming Patient Safety and Quality of Care in NHS Lanarkshire, Clinical Governance Framework 2014-2017*. The areas covered to include:

- Safe care
 - Scottish Patient Safety Programmes (acute, maternity, paediatrics, primary care, mental health)
 - HSMR
 - Board clinical risk register
 - Identification and learning from clinical adverse events – focusing on the implementation of recommended actions in response to significant adverse events and identifying and responding to emerging trends associated with less serious events
 - Staff training and appraisal (exception reporting)
 - Control of infection
 - Reliable rescue
 - Protection of vulnerable people
 - Radiation safety
 - Management of controlled drugs
- Effective care
 - Healthcare Improvement Scotland and other reviews and inspections
 - Effective research and development governance arrangements
 - Implementing evidenced based practice through the use of guidelines, protocols, audits and quality improvement methods
 - Effective medicine management
 - Quality assurance of screening programmes (exception reporting)
 - Cost effective use of medicines
 - Public Health Governance in relation to health protection, health inequalities, health improvement and screening programmes and risk management
- Person centred care
 - The quality ambition of person centred care is overseen by the Care Assurance Board. The Chair of the Care Assurance Board will provide exception reporting to the Healthcare Quality Assurance and Improvement Steering Group
- Quality infrastructure and systems
 - Ensure adequate divisional healthcare governance systems and processes through the Acute Clinical Governance and Risk Management Committee and Joint CHP Clinical Governance and Risk Management Committee with issues escalated as appropriate to the Healthcare Quality Assurance and Improvement Steering Group

- Development of speciality and service key quality indicators and dashboards with a focus on continuous quality improvement

Remit

To ensure co-ordination of all quality assurance and improvement activities across NHS Lanarkshire through:

- Reviewing and on-going implementing and monitoring of the *Strengthening Quality in Lanarkshire* strategy for NHS Lanarkshire building
- Supporting the development and implementation of quality goals for the organisation
- Developing, implementing, monitoring and reviewing annual work programmes for *Strengthening Quality in Lanarkshire*
- Ensuring quality assurance and improvement support is provided throughout NHS Lanarkshire to achieve maximum benefit in maintaining and improving quality of health and healthcare
- Receiving reports from the Joint CHP Clinical Governance and Risk Management Committee and Acute Clinical Governance and Risk Management Committee and other groups in line with the structure taken actions are appropriate on issues escalated
- Ensuring appropriate actions are taken in response to internal reports and to externally generated reports from NHS Healthcare Improvement Scotland, Audit Scotland and other relevant bodies
- Overseeing the quality assurance and improvement structures within NHS Lanarkshire by, where appropriate, establishing and reviewing groups and monitoring their achievement against the work programme
- Ensure that any policies which come before the Quality Assurance and Improvement Steering Group for approval have been through due process as outlined within the NHS Lanarkshire Policy on Developing Policies, are considered timeously and are approved within the author’s specified timescale for the consultation and approval process. Receive periodic reports on the monitoring outcomes indicating the effectiveness of any policies endorsed.
- Be assured that NHS Lanarkshire that groups reporting into the Quality Assurance and Improvement Steering Group have in place a managed system for clinical policies and receive periodic reports confirming corporate policy management.

Membership:

Chairman: The Group will be chaired by the NHS Lanarkshire Medical Director with the NHS Lanarkshire Director of Nursing, Midwives and Allied Health Professionals and Director of Public Health as deputies

Members: Medical Director, NHS Lanarkshire
 Director of Public Health, NHS Lanarkshire
 Director of Nursing, Midwives and Allied Health Professionals, NHS Lanarkshire
 Director of Organisational Development, NHS Lanarkshire
 The chairs (or nominations) of the Acute Clinical Governance and Risk Management Committee and Joint CHP Clinical Governance and Risk

Management Committee
Divisional Nursing Director, Acute Services
Divisional Nursing Director, Primary Care
Associate Director of Nursing for Children and Families and Head of Midwifery
Head of Clinical Governance and Risk Management
Director of NMAHP Practice Development
Head of Patient Affairs
Corporate Risk Manager
Corporate Clinical Quality Manager
Director Acute Division
General Manager CHP South
General Manager CHP North (TBC)

Deputies: Each member will identify a single named deputy

Right of attendance: Other members of the Lanarkshire NHS Board will have right of attendance at any meeting

Term of Office of Member: Members are appointed ex-officio

Quorum

To be quorate meetings will require the attendance of not less than five members of the Group.

Meetings

Meetings will be held a minimum of five times a year.

Additional meetings will be held as required with the agreement of the chairman and two members of the Group.

Minutes

A formal minute of all meetings and of decisions taken will be recorded.

Reporting:

The Healthcare Quality Assurance and Improvement Steering Group will report to the Healthcare Quality Assurance and Improvement Committee of the Lanarkshire NHS Board.

- A. An annual report will be submitted to the Healthcare Quality Assurance and Improvement Committee in May / June of the year for the preceding year April to March
- B. A *Strengthening Quality in Lanarkshire* work programme for the coming year will be agreed in spring of each year and submitted to the Lanarkshire NHS Board. This will take account of healthcare quality assurance and improvement priorities arising in the previous year, the annual report of the Director of Public Health, published work plans of Healthcare Improvement Scotland and Audit Scotland, the corporate objectives and local delivery plan
- C. Minutes of each of meeting of the Steering Group will be submitted to the Healthcare Quality Assurance and Improvement Committee

- D. Other reports will be provided at the request of the Healthcare Quality Assurance and Improvement Committee and the Corporate Management Team or as deemed appropriate by the Group

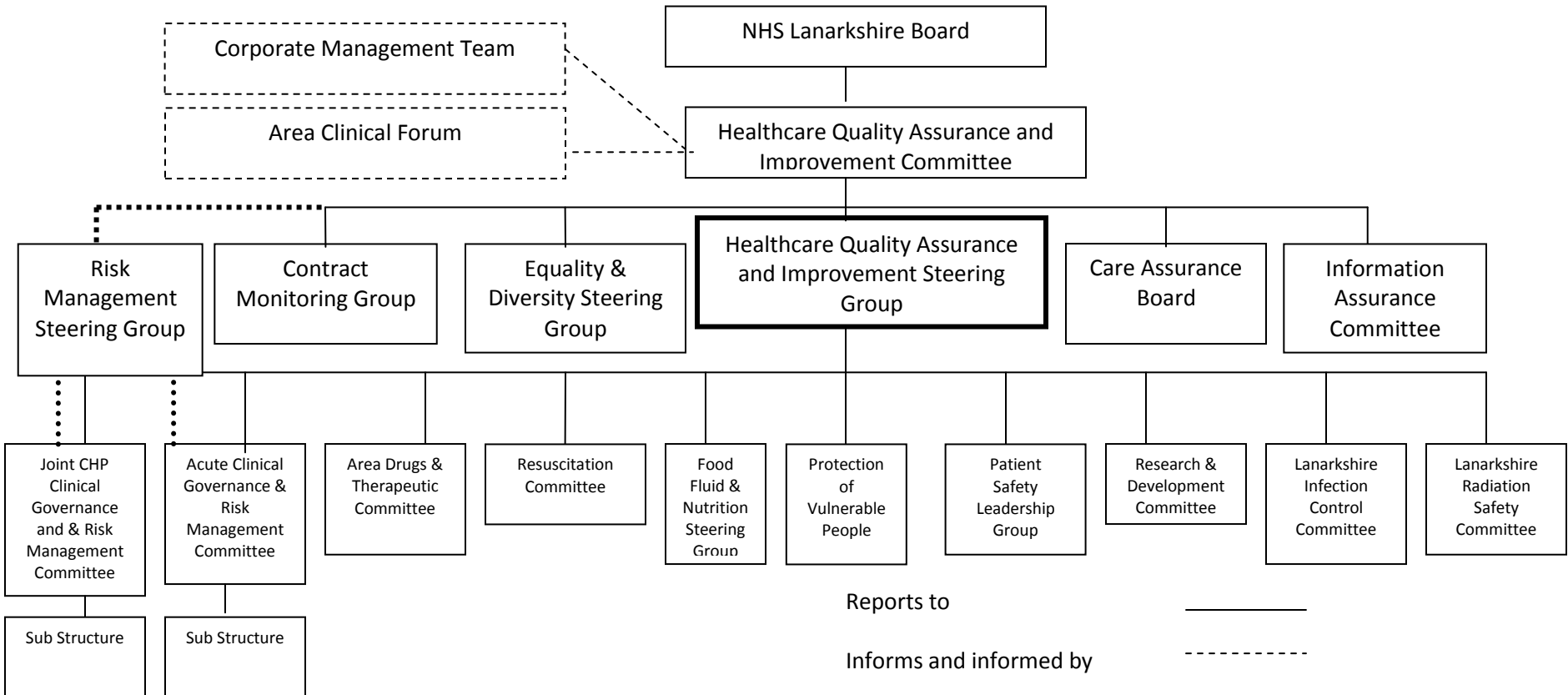
Monitoring and Review

The Healthcare Quality Assurance and Improvement Committee will monitor the functioning of the Healthcare Quality Assurance and Improvement Steering Group.

The Healthcare Quality Assurance and Improvement Committee Steering Group will be reviewed on a three yearly basis in line with NHS Lanarkshire’s *Strengthening Quality in Lanarkshire* strategy.

Previous ToR:	As part of the Health and Clinical Governance Strategy, 2011-14 including annual reviews 2011, 2012, 2013 (previous version ratified 20 May 2013)
Ratified by:	Healthcare Quality Assurance and Improvement Committee February 2014
Author:	Pam Milliken, Head of Clinical Governance and Risk Management
Review date:	May 2015

NHS Lanarkshire Healthcare Quality Assurance and Improvement Structure



Risk Management Steering Group

Terms of Reference

The Role and Function of the Risk Management Steering Group

The Risk Management Steering Group develops, refines, reviews and oversees the implementation of the NHS Lanarkshire Risk Management Strategy, in support of the Board and in collaboration with the Governance Committees as outlined below:

- Healthcare Quality Assurance and Improvement Committee
- Staff Governance Committee
- Audit Committee

The functions of the Group include:

1. The compilation, review of and presentation of the NHSL Strategic Risk Register for the Board, which will enable the Board to focus on key prioritised risk, adequacy of controls and identify subsequent actions where required.
2. Consider regular and exception reports on Risk Management performance, review and improvements to Strategy and Framework as identified through the Schedule of Reporting.
3. Ensure that planning for change and improvement at every level in the Organisation incorporates risk management plans.
4. Provide an Annual Review Report and Prospective Annual Work Plan to provide assurance on the internal controls.

Membership of the Risk Management Group

Core Members: Chief Executive (Chair)

Director of Finance
Director of Human Resources
Medical Director
Director for Nurses, Midwives and the Allied Health Professions
Director of Public Health and Health Policy
Director of Acute Services
Director, North Lanarkshire Community Health Partnership
Director, South Lanarkshire Community Health Partnership
Director for Planning and Performance

Supported By:

Head of Clinical Governance and Risk Management
Corporate Risk Manager
Internal Audit Manager

Chair of Area Partnership Forum
Chair of Area Clinical Forum
General Manager, Occupational Health and Safety / Head of Health and Safety
General Manager, Property and Support Services Department
Board Secretary

Recipients of Minutes

Healthcare Quality Assurance and Improvement Committee
Audit Committee
Occupational Health and Safety Management Group
Operational Divisional Partnership Groups
Acute Clinical Governance and Risk Management Group
Joint CHP Clinical Governance and Risk Management Group
Staff Governance Group

Meetings

The Risk Management Steering Group will meet every 2 months.

QUORUM

Shall be 6 members

TERMS OF OFFICE

The representatives will hold office until Chair terminates the position with the agreement of the committee or an agreed substitute is allocated.

Monitoring and Review

The effectiveness and constitution of the RMSG will be reviewed when required, or no less than every 3 years

(Revised by the RMSG October 2013)

Joint Community Health Partnership
Clinical Governance and Risk Management Committee

Terms of Reference

The Role and Function of the Committee

The key role of the Joint Community Health Partnership Clinical Governance and Risk Management Committee is to be an executive group for the Community Health Partnerships (CHPs), agreeing the quality assurance and improvement work schedule for the CHPs, monitoring activity, reassuring the organisation on clinical governance, patient safety, learning from adverse events, risk management and prioritising activity. This group will be supported by a range of groups which will ensure actions in relation to clinical governance and risk management standards are progressed and practice is reviewed across primary care.

The key functions of the Committee will include:

1. The Committee will have responsibility for the area of quality assurance and improvement, patient safety, learning from adverse events, clinical risk management within the CHPs
2. The Committee will report to the Healthcare Quality Assurance and Improvement Steering Group and the Risk Management Steering Group providing reassurance to the organisation on quality assurance and improvement and risk management issues within the CHPs, actioning, escalating and cascading issues as appropriate
3. The Committee will develop and agree the annual work programme in line with the NHS Lanarkshire's Transforming Patient Safety and Quality of Care work programme and reflecting the priorities arising within the CHPs
4. The Committee will allocate this work programme across the groups within the CHPs clinical governance and risk management structure
5. The Committee will oversee the clinical governance and risk management structures within the CHPs by establishing and reviewing groups and monitoring their achievement against the work programme
6. The Committee will set out an effective reporting mechanism for groups within the clinical governance and risk management structure to adhere to, including requiring an annual status report, monitoring information and reviews of groups functioning through self-assessment
7. The Committee will contribute to the annual NHS Lanarkshire report on clinical governance
8. The Committee will ensure external reviews and self-assessments are completed appropriately, ensure that proper action planning takes place before review visits and ensure timely implementation of issues which arise from both self-assessments and post visit action plans
9. Ensure that any policies which come before the Joint CHP Clinical Governance and Risk Management Committee for approval have been through due process as outlined within the NHS Lanarkshire Policy on Developing Policies, are considered timely and are approved within the author's specified timescale for the consultation and approval process. Receive periodic reports on the monitoring outcomes indicating the effectiveness of any policies endorsed.

10. Be assured that NHS Lanarkshire that groups reporting into the Joint CHP Clinical Governance and Risk Management Committee have in place a managed system for clinical policies and receive periodic reports confirming corporate policy management.

Membership of the Committee

Core Members:

Medical Director, Primary Care (Chairperson)*
Head of CHP North*
Director of Nursing, Primary Care*
Associate Medical Director, CHP South*
Associate Medical Director, CHP North*
Associate Medical Director, Mental Health and Learning Disabilities
Associate Director of Nursing, Primary Care
Associate Director of Nursing, Mental Health and Learning Disabilities
Associate Director of Nursing, Long Term Conditions
Associate Director of Nursing Children and Families
Associate Medical Director, Out of Hours
Clinical Director Paediatrics
Associate Director of Allied Health Professionals
Director of Public Health Dental Services
Clinical Director, Psychology
Chief Pharmacist, Primary Care
General Manager x 2 (one North and one South)
Healthcare Manager, Shotts Prison
Lead Clinician, Lanarkshire Sexual Health Service
Head of Clinical Governance and Risk Management
Corporate Risk Manager
Head of Patient Safety and Improvement
Head of Patient Affairs
Partnership Representative
Clinical Quality Assistant

Deputies:

Each member of the Committee will identify a deputy to attend meetings in their absence. The Director CHP North will be deputised by the Director CHP South

Co-opt Members:

Individuals who are leading particular areas of work may be co-opted on to the Committee. This will allow them to present to and be involved in the discussions of the Committee. Co-opt Members could also include Palliative Care clinicians.

Reporting Arrangements

The Committee will report into the NHS Lanarkshire Healthcare Quality Assurance and Improvement Steering Group, the NHS Lanarkshire Risk Management Steering Group and the CHP Operating Management Committees, ensuring that the Committee influences decision making at a senior level within these parts of the organisation. The matrix attached show the groups which report into the Committee.

Meetings

The Committee will meet quarterly. Virtual meetings can take place if an issue cannot wait until the next quarterly meeting.

The standard agenda for meetings should be:

- 1 Meeting Organisation
 - 1.1 Apologies
 - 1.2 Minutes
 - 1.3 Notification of AOCB and Hot Spots
- 2 Work Programme and Prioritisation (including outcomes)
- 3 Receiving Reports / Monitoring Activity
- 4 Reassurance for NHSL
 - 4.1 Preparation of Reports
 - 4.2 Hot Spots

Quorum

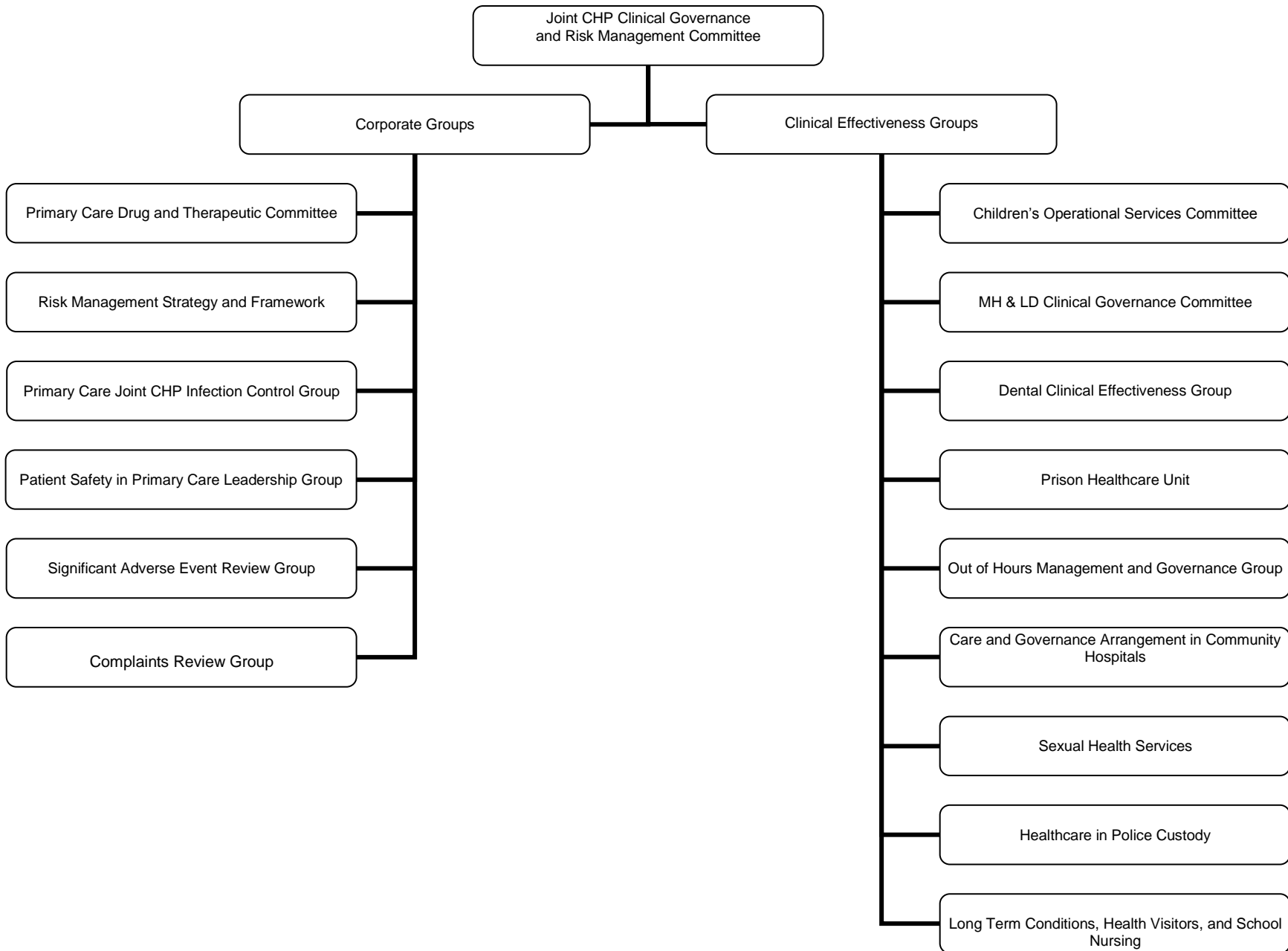
Shall be 6 members including at least two of those * above in the membership, one of whom will chair the meeting in the absence of the Chairperson.

Monitoring and Review

The Healthcare Quality Assurance and Improvement Steering Group will monitor the functioning of the Committee through the reports submitted by the Committee to the Steering Group.

The Joint CHP Clinical Governance and Risk Management Committee will be reviewed on an annual basis.

Ratified by:	Joint CHP CGRM Committee
Annual reviews:	2011, 19 April 2012 (addition to membership of Healthcare Manager, Shotts Prison and Lead Clinician, Lanarkshire Sexual Health Service), 2013
Date ratified 2013 review:	19 April 2013
Date ratified 2014 review:	30 January 2014 agreed, pending wider review in line with changes in quality assurance and improvement arrangement in acute and corporate. This review will be undertaken in tandem to changes to acute. 20 June 2014 in response to changes made by A. Armstrong (reference to patient safety and learning from adverse events, new subgroups, reference to influencing management groups, work programme to consider outcomes, additional members)
Author:	Pam Milliken, Head of Clinical Governance and Risk Management
Review date:	June 2015



**Acute Division Clinical Governance and Risk Management Committee
Terms of Reference**

The Role and Function of the Committee

The Acute Clinical Governance and Risk Management Committee is an executive group for the Acute Division, providing governance and assurance that supports staff in the delivery of safe, effective, person centred care in the Acute Division and reassuring the organisation on clinical governance, patient safety, learning from adverse events, risk management and prioritising activity. This group will have direct oversight of the work of the Hospitals and Access Directorate Quality Assurance, Improvement and Patient Safety Groups and the sub-groups of Clinical Effectiveness and the Quality Assurance, Improvement and Patient Safety Forum. A core group of the Divisional Medical and Nurse Directors together with the Director of Acute Services will prepare regular reports on Complaints, Patient feedback, Patient Opinion, Significant Adverse Event Review (SAER) Action plans and the Clinical Risk Register.

Acute Clinical Governance and Risk Management Committee:	
Formal representation from Hospital Quality Assurance, Improvement and Patient Safety Groups	
Formal representation from Access Directorate Quality Assurance, Improvement and Patient Safety Group	
Formal representation from other pan-Lanarkshire groups e.g. Infection Control, Critical Care Nurse Consultant (manages Hospital Emergency Care Teams), Head of Pharmacy, Chair of Blood Transfusion Committee, Heads of Patient Affairs, Clinical Governance, Patient Safety, Risk Management	
Sub-groups:	
Quality Assurance, Improvement and Patient Safety Forum (Acute):	Clinical Effectiveness Group:
Representation from clinical teams on Hospital and Directorate Quality Assurance, Improvement and Patient Safety Groups	Dashboards and Data Intelligence
Leads for SPSP workstreams	Case note reviews (3 x 2 matrix)
SPSP Fellows	Audits/ National Reports /benchmarked guidance (e.g. SIGN, WoSCan, Profiles etc)
Site Leads for M & M	

In order to provide assurance on quality to the organisation, it is proposed that it will be the responsibility of the Divisional Medical and Nurse Directors to give a regular report from the ACG&RM Committee as the first item on the agenda of the Acute Divisional Management Team and the Operating Management Committee and will receive strategic direction from these groups.

The key functions of the Committee will include:

1. The Committee will have the ultimate responsibility for the area of clinical governance, patient safety, learning from adverse events and clinical risk management within the Acute Division

2. The Committee will develop and agree areas of work in line with the NHS Lanarkshire's Transforming Patient Safety and Quality of Care in NHS Lanarkshire Strategy 2014-2017 work programme and reflecting the priorities arising within the Acute Division
3. The Committee will oversee the clinical governance, quality improvement and risk management structures within the Acute Division by where appropriate establishing and reviewing groups and monitoring their achievement
4. The Committee will set out an effective reporting mechanism for groups within the acute clinical governance, quality improvement and risk management structure
5. The Committee will contribute to the annual NHS Lanarkshire report on Quality Assurance and Improvement
6. The Committee will ensure that issues raised by external bodies, NHS staff or patients/carers are brought to the attention of the accountable bodies within the Acute Division for response and action
7. Ensure that any policies which come before the Acute Clinical Governance and Risk Management Committee for approval have been through due process as outlined within the NHS Lanarkshire Policy on Developing Policies, are considered timeously and are approved within the author's specified timescale for the consultation and approval process. Receive periodic reports on the monitoring outcomes indicating the effectiveness of any policies endorsed.
8. Be assured that NHS Lanarkshire that groups reporting into the Acute Clinical Governance and Risk Management Committee have in place a managed system for clinical policies and receive periodic reports confirming corporate policy management.

Membership of the Committee:

Core Members:

Divisional Medical Director, Acute (Chairperson)*
 Divisional Nursing Director, Acute*
 Divisional Director Acute / Director of Access*
 Associate Medical Directors*
 Site Chiefs of Medical Services*
 Site Chiefs of Nursing*
 Control and Infection
 Chief Pharmacist, NHS Lanarkshire
 Senior Clinical Pharmacist
 Head of Patient Affairs
 Head of Clinical Governance and Risk Management
 Head of Patient Safety and Improvement
 Corporate Clinical Quality Manager
 Corporate Risk Manager
 Clinical Skills Practice Development Specialist
 Hospital Risk Managers

Personal Secretary, Medical Director Acute (secretary)

Deputies:

Each member of the Committee will identify a deputy to attend meetings in their absence.

Co-opt Members:

Individuals who are leading particular areas of work may be co-opted on to the Committee. This will allow them to present to and be involved in the discussions of the Committee.

Reporting Arrangements

The Committee reports to the NHS Lanarkshire Healthcare Quality Assurance and Improvement Steering Group and the Acute Divisional Management Team and informs and is informed by the NHS Lanarkshire Risk Management Steering Group. The structure attached shows the groups which report into the Committee.

Quorum

Shall be 6 members including at least three of those* above in the membership, one of whom will chair the meeting in the absence of the Chairperson.

Monitoring and Review

The Healthcare Quality Assurance and Improvement Steering Group will monitor the functioning of the Committee through the reports submitted by the Committee to the Steering Group.

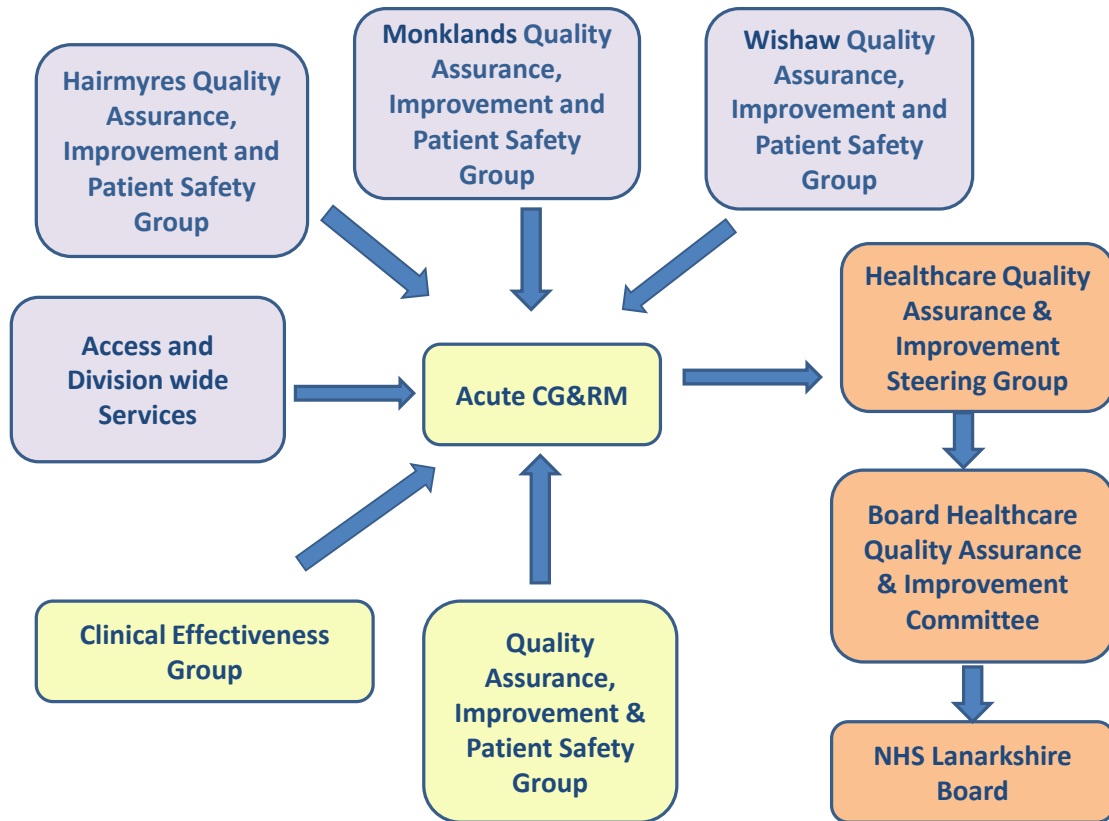
The standard agenda for meetings should be:

1. WELCOME AND APOLOGIES
2. PREVIOUS MINUTES AND ACTION NOTE
3. MATTERS ARISING
4. PROVIDING SAFE CARE
5. LEARNING FROM ADVERSE EVENTS
 - Newly commissioned SAERs noted
 - Progress with ongoing SAERs
 - Complete SAERs – monitoring of action plans
 - Discussion of Datix with SBARs where SAER not commissioned.
6. CLINICAL EFFECTIVENESS
7. QUALITY ASSURANCE
8. PATIENT FEEDBACK
 - Complaints and Action Plans
 - Ombudsman’s Reports
 - FAI’s as required
9. REPORTS FROM SITE QUALITY ASSURANCE AND IMPROVEMENT AND PATIENT SAFETY GROUPS
10. SHARING LEARNING FROM OTHERS
11. AOCB

The Acute Clinical Governance and Risk Management Committee will be reviewed on an annual basis.

Previous ToR:	Acute Clinical Governance and Risk Management Committee, 2010
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	(reviewed 2011, 2012, 2013)
Ratified by:	Healthcare Quality Assurance and Improvement Steering Group
Date ratified:	22 August 2014
Author:	Jane Burns, Medical Director (Acute) and Pam Milliken, Head of Clinical Governance and Risk Management
Review date:	May 2016



NHS LANARKSHIRE
EQUALITY AND DIVERSITY STEERING GROUP
TERMS OF REFERENCE

Role of the Group

The role of the Equality and Diversity Steering Group is to provide strategic and operational leadership and ensure the effective delivery of continuous improvement across NHS Lanarkshire in equalities.

This will be achieved by mainstreaming the equality agenda throughout all areas of NHS Lanarkshire's health improvement, healthcare and employment practice activity.

The Group will influence the effective development of Strategy and Policy on behalf of the Board of NHS Lanarkshire and will be accountable for implementation of Strategies, Policies and Plans across the equality agenda through the production and delivery of an annual action plan to:

- ❖ Value diversity and ensure equality of care, treatment, and access to services which are appropriate and sensitive to individuals needs and eliminate discrimination.
- ❖ Maintain contemporary knowledge and understanding of E&D matters and ensure that such matters are of influence in the strategic / operational thinking and decision-making of managers and staff.
- ❖ Operate an effective system of performance management and monitoring to ensure progress against statutory requirements, agreed policies and action plans.

Through its strategies, plans and actions the Group will pay due regard to the three needs of the General Equality Duty, namely to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

Key Areas of Activity for the Group will include:

- ❖ Energising managers and staff of NHS Lanarkshire and strategic partners and to create the widest possible understanding and impact of E&D issues.
- ❖ Developing effective and inclusive methods of communication, improving access to services and enhancing the availability of advocacy for patients, carers and staff in the ongoing development of culturally-competent health improvement and health services in Lanarkshire.

- ❖ Policy development and implementation of good practice to promote the enhanced performance of NHS Lanarkshire consistent with national statutory requirements and with close regard to the demographic and health status of the communities of Lanarkshire.
- ❖ Support the implementation of the Board's Patient Focus and Public Involvement Strategy by working in partnership with the Public Partnership Forums, Local Authorities and Third Sector to proactively engage with local communities.
- ❖ Development of methods to identify and continuously monitor the diverse health and healthcare needs of the different communities of Lanarkshire. Ensure that such needs assessment is of influence in planning and decision-making.
- ❖ Influence the development of Human Resource Policies and practice to promote the performance of NHS Lanarkshire as an exemplar employer; to deliver equality, fairness and consistency in management decision-making; and to eliminate discrimination across all areas of employment practice.
- ❖ Influence the design and delivery of staff development and training programmes to create continuous improvement in the skills, knowledge and confidence of staff, recognising and valuing the positive impact of equality and diversity as a feature of a high quality, progressive, caring, public / patient focussed NHS.
- ❖ Review and develop systems of data collection to support and inform effective performance management, reporting and decision-making.

MEMBERSHIP

Susan Dunne, Head of Organisational Development (Chair)
 Calvin Brown, Divisional Communications Manager
 Tom Bryce, Unit General Manager
 Eileen Clarke, Senior Nurse, Cancer and Diagnostic Divisions
 Bob Devenny, Head of Spiritual Care
 Gillian Lindsay, Assistant Health Promotion Manager
 Peter McCrossan, Associate Director of NMAHPs
 Catherine McGinty, Staff Side Representative
 Marie Porteous, Head of Sustainability and Environmental Management - PSSD
 Hina Sheikh, Equality and Diversity Manager
 Shona Welton, Head of Patient Affairs
 John White, Divisional HR Director

FREQUENCY OF MEETINGS

Meetings will be held quarterly. Additional meetings will be held as required with the agreement of the Chairperson. Meetings will be considered quorate if at least one third of members are in attendance.

MINUTES

A formal Minute of all meetings and decisions taken will be recorded and circulated to Members of the Steering Group.

REPORTING ARRANGEMENTS

The NHS Lanarkshire Equality and Diversity Steering Group reports to the Staff Governance and Healthcare Quality Assurance and Improvement Committees. These are formal sub-committees of the NHS Lanarkshire Board.

The Minutes of meetings of the Steering Group will be submitted to the Staff and Clinical Governance Committees for information along with 6 monthly progress reports against the Group's Annual Action Plan. In addition, an Annual Report will be provided to the Staff and Healthcare Quality Assurance and Improvement Committees and forwarded to the Board thereafter.

In accordance with the Public Sector Equality Duties (PSED) announced in May 2012, NHS Lanarkshire will also publicly publish a range of information and reports. This will be co-ordinated by the Equality and Diversity Steering Group.

REVIEW

The Terms of Reference will be reviewed annually.

First Issued:	June 2008
Reviewed:	September 2010
Reviewed:	September 2012
Reviewed:	August 2013
Next Review:	18 December 2014

Care Assurance Board
Terms of Reference

Purpose

To provide an overarching care assurance system which promotes the provision of a culture where care is consistently person-centred, clinically effective and safe, for every person, every time, and where caring behaviours will have at their heart the NHS Lanarkshire organisational values of fairness, respect, working together and quality.

Policy Context

Although not exclusively, the following key policy drivers will provide the policy context:

- 2020 Vision., Scottish Government, August 2012
- A Healthier Future, NHS Lanarkshire, June 2012
- AHPs as agents of change in health and social care., Scottish Government, June 2012
- The Healthcare Quality Strategy for NHSScotland., Scottish Government, May 2010
- Midwifery 2020: Delivering Expectations, September 2010
- Rights, Relationships and Recovery: Refreshed., Scottish Government, June 2010
- Better Together: Scotland’s Patient Experience Programme, November 2008
- Leading Better Care., Scottish Government, May 2008
- Better Health, Better Care., Scottish Government, December 2007
- Modernising Nursing Careers – setting the direction, Department of Health, 2006
- Learning from the Francis Report

Remit

To receive information, updates and reports from the sources below and to proactively anticipate or act on care governance issues, ensuring that causal links are made and organisational learning opportunities are recognised and shared. To explore themes and trends and direct improvement activities to ensure the spread of best practise.

To commission specific actions to enhance the quality of care delivery.

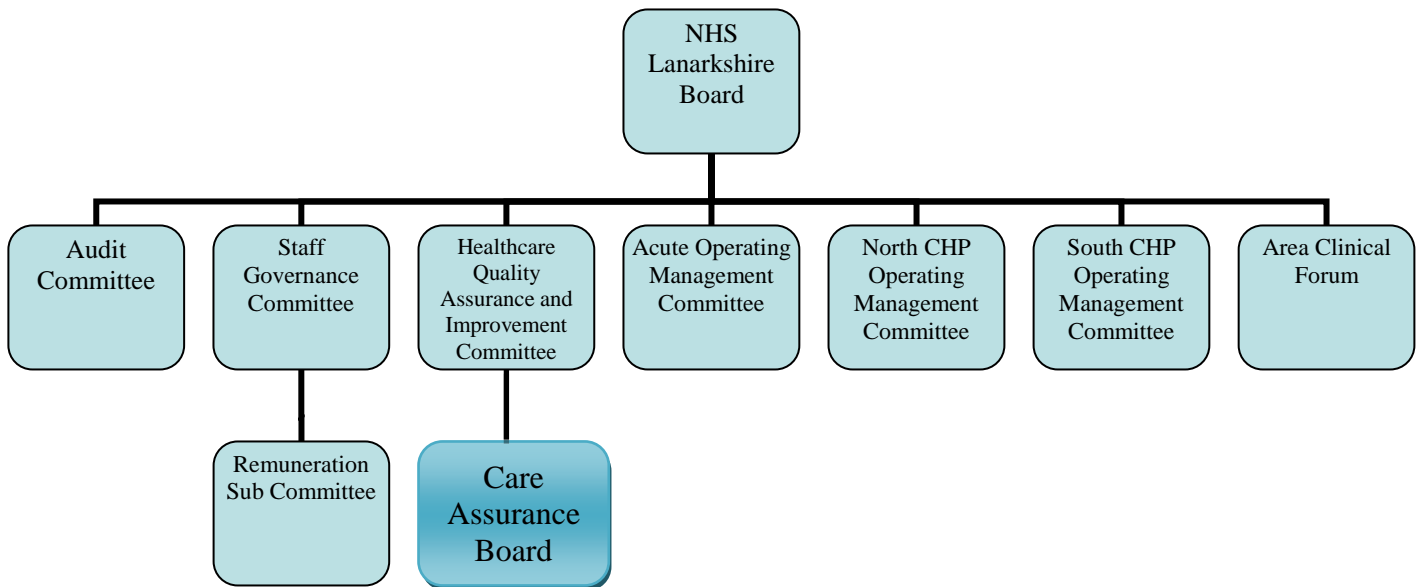
- Acute ward dashboard/mental health SRI/Community dashboard
- Care environment observations
- Patient Experience Indicators
- Leading Better Care
- Volunteering
- Older People In Acute Hospitals work
- Learning from feedback, comments, concerns and complaints
- Datix reports
- Any actions arising from the FRANCIS report specific to this area

Name	Title
Rosemary Lyness (Chair)	NMAHP Executive Director
Noreen Kent	Associate Director of Nursing – Person-Centred Health and Care

Margot Russell	Deputy Director NMAHP Practice Development Centre
Shona Welton	Head of Patient Affairs
	Non-Executive Director
	Patient Representative from PPF x2
	ANMAC Representative
	Maternity services
	AHP
	Primary Care
Bob Devenny	Head of Spiritual Care
	Clinical Governance Lead, Hairmyres
	Clinical Governance Lead, Monklands
	Clinical Governance Lead, Wishaw
	Partnership
	Staff Side Representation
	Mental Health
	Pharmacy
	Medic - ACF

Governance

The Care Assurance Board will report through the existing Healthcare Quality Assurance and Improvement Committee to the NHS Lanarkshire Board.



Conduct of Meetings

- Meetings will be considered quorate if 50% of the full membership is in attendance including the Chair or deputy
- Members should make every effort to attend, however if unable to do so then a deputy may be sent
- All correspondence including papers for meetings will be issued by email

- Members with agenda items will submit reports/updates at least one week before the meeting date
- Final agenda and papers will be issued five days prior to the meeting

Frequency of Meetings

The Board will meet every six weeks.

Secretariat

Secretarial support will be provided.

Previous ToR:	New group
Ratified by:	Healthcare Quality Assurance and Improvement Committee
Annual reviews:	New group
Date ratified:	September 2013
Author:	Rosemary Lyness, Executive Director NMAPs
Review date:	End December 2014

Information Assurance Committee
TERMS OF REFERENCE

Author:	Dr Philip McMenemy/Craig Tannahill
Responsible Lead Executive Director:	Dr Harpreet Kohli/Alan Lawrie
Endorsing Body:	Healthcare Quality Assurance and Improvement Committee
Governance or Assurance Committee	Information Assurance Committee
Implementation Date:	June 2013
Version Number:	1.7
Review Date:	June 2015

CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author / Authors	Neil Agnew – Corporate Affairs Manager
Consultation Process / Stakeholders:	<ul style="list-style-type: none"> • Information Assurance Committee
Distribution:	<ul style="list-style-type: none"> • IA Committee Membership • Healthcare Quality Assurance and Improvement Committee

CHANGE RECORD			
Date	Author	Change	Version No.
May 2013		1 st draft for review	1.0
June 2013	Craig Tannahill	2 nd draft for review	1.1
June 2013	Craig Tannahill	3 rd draft following review from IG Committee	1.2
July 2013	Craig Tannahill	4 th draft following review by the Clinical Governance Committee	1.3
July 2013	Craig Tannahill	Change in wording to Section 3.5.2, 4.0 and 8.0 following IA Committee meeting 30/07/2013	1.4
September 2013	Craig Tannahill	Change to Section 3.2	1.5
April 2014	Philip McMenemy	Addition of sections 4.12 and 4.13 to TOR Changes to reflect creation of HQAI Committee	1.6
June 2014	Craig Tannahill	Changes to endorsing body, distribution and 4.4 Healthcare Quality Assurance and Improvement Committee.	1.7

1.0 Purpose

The Information Assurance (IA) Committee is a standing committee reporting to the Healthcare Quality Assurance and Improvement Committee, and, ultimately is accountable to the Lanarkshire NHS Board. Its purpose is to support and drive the broader Information Assurance agenda and provide the Board with the assurance that effective Information Assurance best practice mechanisms are in place within the organisation.

2.0 Composition

2.1 Membership

The current membership of the committee is attached at appendix 1 and can be found on Firstport.

The members of this group shall be appointed and reviewed annually as part of the committees review of its Terms of Reference.

2.2 The Chair

The Chair shall be appointed from the membership of the IA Committee and approved by the Healthcare quality assurance and Improvement Committee. The appointment will be for a period of 3 years, renewable for further 3 year terms thereafter.

2.3 Attendance

All members of the IA Committee are required to attend meetings or send representation in their absence for continuity purposes. If the representative from any area is unable to attend then apologies are expected prior to the meetings. The Information Assurance leads provide brief progress reports on their specific areas of work and bring pieces of work to the group for discussion and approval. Organisation IA related Policies and Procedures are also approved by the IA and HQAIC level on behalf of the NHS Board.

3.0 Meetings

3.1 Frequency

This group will meet every 6 weeks.

3.2 Quorum

To be quorate, meetings will require the attendance of not less than five members of the IA Committee who must include Chair or Deputy Chair.

3.3 Agenda and Papers

The agenda comprises of a series of reports or briefings from each of the IA agenda Leads containing updates on progress with work programmes. The meeting agenda and supporting papers will be distributed not later than five working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next IA Committee meeting, prior to submission to the Healthcare quality Assurance and Improvement Committee. Recognising the issue of relative timing and scheduling of meetings, minutes of the IA Committee may be presented in draft form to the next available HQAI Committee meeting. The draft minutes will be cleared by the Chair of the IA Committee prior to submission to the Healthcare quality Assurance and Improvement Committee.

3.5 Reporting

The IA Committee will report regularly on progress of the workplan and the IA strategy to the HQAI Committee, and as required to the Corporate Management Team.

- 3.5.1 An annual IA workplan will be submitted to the HQAIC in April for the forthcoming year April to March.
- 3.5.2 At every meeting of the HQAI Committee a progress report on the IA workplan will be provided.
- 3.5.3 A mid-year progress report once approved by the IA Committee will be submitted to the HQAI Committee in October and a year end outturn report in April.
- 3.5.4 Minutes of each IA Committee meeting will be submitted to the HQAI Committee and to the Corporate Management Team via the Board Secretary.
- 3.5.5 Other reports will be provided at the request of the Healthcare Quality Assurance and Improvement and the Corporate Management Team or as deemed appropriate by the IA Committee.

3.6 Other

In order to fulfil its remit, the IA Committee may obtain any professional advice it requires and invite, if necessary, external experts and relevant staff representatives to attend meetings.

4.0 Remit

The NHSScotland (NHSS) have directed Boards to make annual submissions to the IA Toolkit. The submission provides the NHSL Board and NHSS with assurance that there is in place an effective IA Framework. The IA Toolkit covers the following elements of information governance:

- ✓ Administration Records
- ✓ Caldicott
- ✓ Confidentiality
- ✓ Data Protection
- ✓ Data Quality
- ✓ Freedom of Information
- ✓ Information Assurance and Planning
- ✓ Information Services
- ✓ Patient Records

Key responsibilities of the Information Assurance Committee:

- 4.1 To ensure that a comprehensive Information Assurance framework and systems are in place throughout the Board in line with national standards.

- 4.2 To inform the review of the Board's management and accountability arrangements for Information Assurance.
- 4.3 To maintain the IA policy and associated IA implementation strategy.
- 4.4 To prepare the annual Information Assurance Assessment for sign off by the Healthcare Quality Assurance and Improvement Committee on behalf of the NHS Board.
- 4.5 To develop the Board's Information Assurance work programme, to ensure delivery of the Information Assurance Strategy.
- 4.6 To ensure that the Board's approach to information handling is communicated to all staff and made accessible by the public through posting of the IA Strategy on the NHSL public website.
- 4.7 To coordinate the activities of staff given data protection, confidentiality, security, information quality, and records management.
- 4.8 To offer support, advice and guidance to the Caldicott Function and Data Protection programme within the Board.
- 4.9 To monitor the Board's information handling activities to ensure compliance with law and guidance
- 4.10 To monitor that training made available by the Board is taken up by staff as necessary to support their role.
- 4.11 Provide a focal point for the resolution and discussion of Information Assurance issues.
- 4.12 To examine and approve relevant policies related to information assurance and security of both IT and other systems
- 4.13 To offer support advice and guidance on issues relating to copyright as this pertains to NHSL activities including electronic media

5.0 Information Assurance

The IA Committee will be responsible for overseeing the delivery of the Information Assurance strategy through regular reports from the relevant leads for the constituent elements of the IA workplan.

6.0 Management and Accountability

Lanarkshire NHS Board has an executive lead for IA and a Caldicott Guardian. These representatives may report back to the Board on the IA Committee's progress and agenda items which may need Board level approval. The Chief Executive has overall responsibility, and is accountable for ensuring that the organisation operates in accordance with the law.

7.0 Authority

The IA Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the IA Committee. The IA

Committee is also authorised to implement any activity which is in line with the terms of reference, as part of the IA work programme, which shall be signed off by the Healthcare Quality assurance and Improvement Committee on behalf of the NHS Board.

8.0 Performance of the Information Assurance Committee

The IA Committee shall review its own performance, effectiveness, and terms of reference on an annual basis, and report on the outcome to the Healthcare quality assurance and Improvement Committee.

The IA Committee shall submit the annual IA Toolkit report to the Board for sign off, prior to submission to IA Toolkit.

Patient Safety Strategic Steering Group Terms of Reference

Making the Safety of Patients everyone’s highest Priority

*“Place the quality of patient care, **especially patient safety**, above all other aims. Engage, empower, and hear patients and carers at all times. Foster whole-heartedly the growth and development of all staff, including **their ability and support to improve the processes in which they work**. Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge. At its core, the NHS remains a world-leading example of commitment to health”*

(The Berwick Review 2013)

1. Name of Committee / Group	Patient Safety Strategic Steering Group
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2. Background and Context	<p>Patient safety is an international, national and locally recognised priority. Current formal systems do not necessarily give a true picture to the extent of harm within healthcare.</p> <p>It is stated that one in 10 patients are harmed through healthcare, but this is based on evidence from more than a decade ago, much of it from outside the UK. More recent research suggests that levels of harm range from 3 – 25% in acute care.</p> <p>In primary care, evidence is sparser but about 9% of primary care records indicate an error in either primary or secondary care, equivalent to 1 in 48 consultations (2%). Studies in community hospitals have suggested adverse event rates of around 15%.</p> <p>In addition, studies suggest that people receive only half of the appropriate care for their condition. The figures are similar for adults and children. Older people and those requiring a longer hospital stay are more likely to experience an adverse event.</p> <p>Overall, there is a large amount of research available about levels of harm in acute care and a lesser amount in primary care. However this research uses different methods (record review versus observation) and varying definitions of what counts as an adverse event so it is difficult to draw firm conclusions.</p> <p>The most recent research from the USA suggests that more than one in 10 people admitted to hospital may suffer an adverse event and rates of misdiagnosis, harm in primary care and medication errors are also high.</p> <p>In the UK, Vincent and colleagues used patient records from 1999 and found an adverse event rate of 10.8%, or 11.7% of all people</p>
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admitted once multiple adverse events were accounted for.

More recently, Sari and colleagues studied 1,006 hospital admissions between January and May 2004 using case note review and a routine reporting system. Patient safety incidents were identified in **22.9%** of cases and the authors estimated that around **10.9%** of people admitted suffered one or more harms.

(Levels of Harm Evidence Scan - Health Foundation 2011)

Definition of Harm

The simplest definition of harm in healthcare is a negative effect, whether or not it is evident to the patient.

Healthcare levels of harm are higher than for air, road and rail transport and people in high risk occupations such as construction.

Our Quality Vision

Achieve transformational improvement in the provision of safe, person centred and effective care for all of our patients

Our Patient safety Vision

NHS Lanarkshire will be the safest health and care system in Scotland

- No avoidable deaths
- Reduce avoidable harm
- Build a sustainable infrastructure for patient safety and improvement
- Development of a sustainable safety culture
- Safe, reliable and person centred care

The Board sets patient safety and endorses it as a strategic priority and is responsible for: formulating strategy, ensuring accountability and shaping culture.

Levels of harm locally need to be identified and will be clearly articulated within the Patient Safety Prioritised plan and aligned to the patient safety aims and goals to reduce avoidable harm.

The development of a patient safety measurement framework and plan will be an essential component of the prioritised plan for patient safety improvement and will inform and support teams, directorates and sites with its implementation.

- To co-ordinate, oversee and monitor progress and implementation of the Board's Patient Safety Strategy and prioritised plan for patient safety. This will

3. Purpose

encompass: national programmes of work as well as locally determined work streams and activities based on the identification of the boards local patient safety priorities.

The patient safety plan and programme of work is ambitious and transformational therefore “creating the necessary conditions” to support successful implementation will be an essential component to enable improvement in patient safety and achieve the aims, goals and demonstrate a reduction in harm.

- Provide executive strategic, clinical and operational leadership advice and expertise for patient safety improvement including
 - Oversight, implementation and monitoring of progress of the plan
 - Influencing the future strategic direction of patient safety across NHS Lanarkshire.
- Identify areas of challenge and barriers to improvement and agree actions to address these
- Provide a vehicle for shared learning and cross fertilisation of best practice, discussion and dialogue in relation to patient safety improvement work.
- Promote collaborative, multidisciplinary working and oversee the implementation of a local patient safety collaborative as a vehicle to support successful testing implementation and spread of the patient safety plan.
- Oversee the development of a plan of patient safety local activities, learning events, seminars and annual celebrating success local conference.
- Review national and international guidance and advice on patient safety initiatives and improvement work and consider relevance and applicability to the organisation.
- Lead on the development and dissemination of agreed patient safety advice and guidance for the board and other patient safety programme or work stream specific committees and groups.
- Ensure effective alignment and integration of other strategic organisational priorities and improvement work to support a cohesive improvement agenda across the organisation that minimises confusion and maximises impact.

- Ensure that patients and their families are actively listened to and engaged in the delivery of safe care is an essential component of the patient safety agenda and local plan.
 - The group will review the evidence base and consider how it will ensure patients, families and carers are actively involved in all patient safety improvement work.
 - Oversee the alignment and integration of the Person Centred Health and Care agenda with patient safety improvement work

- Receive reports in relation to the outcome of morbidity and mortality reviews and top patient safety reported Datix issues and themes.

- Monitor rates of harm identified through the use of the Global Trigger Tool, 2 x 3 Matrix Mortality Reviews and other adverse event trigger tools used as part of the patient safety improvement agenda. Ensuring learning is shared and disseminated across the organisation.

- The Patient Safety Strategic Steering Group will provide an overarching framework and agree a progress reporting structure for all of the Patient Safety Groups and will:
 - Provide strategic oversight to patient safety groups
 - Receive progress and update reports
 - Request formal presentations from relevant groups and teams to show case progress and best practice examples of patient safety improvement work

Building the will for patient safety and delivery of a genuine culture change in the NHS to ensure patient safety is everyone's highest priority and to reduce avoidable harm are fundamental parts of every single employee's role, with leaders at every level of the system understanding and championing a culture of patient safety and harm-free care.

Executive, clinical and managerial engagement and ownership are crucial elements to support successful testing, implementation and spread of patient safety improvement work.

The group will:

	<ul style="list-style-type: none"> Oversee the development of an engagement and communication plan to support successful implementation to ensure there is active participation engagement and local ownership and accountability of patient safety across the organisation. Build a momentum and urgency for change to support the implementation of the Patient Safety Improvement Plan across NHS Lanarkshire
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4. Connectivity – reports to and rationale	<p>The Group reports to the Healthcare Quality Assurance and Improvement Steering Group.</p> <p>The Group will produce progress reports to the following groups:</p> <ul style="list-style-type: none"> The Board Healthcare Quality Assurance and Improvement Committee <p>The Group will oversee the development of an Annual Patient Safety Report showcasing achievements and progress of work</p>
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5. Co-chairs	Iain Wallace Medical Director and Rosemary Lyness, Director of NMAPs
6. Vice Chair	Jane Murkin Head of Patient Safety and Improvement
7. Membership NB: The group will invite co-opted members as appropriate for the discussion This group was initiated by Iain Wallace and held its first meeting on: February 25th 2014	<p>Co-chairs</p> <p>Deputy Chair</p> <p>Head of Clinical Governance</p> <p>Executive Leads for Patient Safety</p> <p>Clinical Leads for Patient Safety</p> <p>SPSP Fellows</p> <p>Patient Safety Improvement Advisors</p> <p>Clinical Quality Staff supporting Patient Safety</p> <p>Additional membership to be considered:</p> <p>Practice Development</p> <p>Site Director</p> <p>Associate Nurse Director</p> <p>HR</p> <p>Communications Department</p> <ul style="list-style-type: none"> Each meeting will be structured with a predetermined agenda agreed by the Medical Director and Head of Patient Safety and Improvement. Minutes and agenda will be sent out prior to meetings and distributed to members and those in attendance not less than three clear working days in advance of the meeting.

	<ul style="list-style-type: none"> • Apologies will be required for those members who are unable to attend • Members who are unable to attend should seek approval for a nominated deputy.
8. Quorum	Chair or Vice Chair plus not less than 8 members of the group.

9. Frequency of meetings	6 weekly May initiate and commission specific working groups
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10. Secretary servicing committee / group	Secretarial support will be provided by?
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11. Review date for Terms of Reference and Membership	Draft prepared for April 2014 meeting Will be reviewed annually - April 2015
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<p>12. Organisational Capacity and capability for Patient Safety Improvement</p> <p>Building capacity and capability for patient safety and quality improvement will be an essential element to support successful implementation of the prioritised patient safety plan.</p> <p>The prioritised plan will set out an approach to build capacity and capability in leadership and implementation of patient safety improvement, effective team working and human factors and reliability theory and the model for improvement, including other improvement methodologies and tools to support successful implementation. This group will oversee its implementation and monitor progress on achieving the aims of building a sustainable infrastructure for patient safety and quality improvement.</p> <p>Oversee the findings, presentation and sharing the baseline assessment Patient Safety Culture Survey and agree future direction and timescales for measuring cultural change within teams and across the organisation.</p> <p>Partnerships and Engagement</p> <p>(a) To engage with local authority and partner organisations and foster a culture of openness, in developing safe, effective and person centred clinical care across boundaries and promoting a whole system approach to patient safety improvement</p> <p>(b) To work with external national organisations in relation to patient safety and quality improvement : SGHD, Healthcare Improvement Scotland, NES,</p>

Signed
Dated 23 May 2014