NHS Governance – Clinical Governance
North Ayrshire Health and Social Care Partnership

1. Are services safe, effective, and evidence-based?

Mental health inpatient services in A&A through robust risk assessment and proactive approach to collaborative care have shown a reduced number of significant adverse events whilst reducing average length of stay. Services continue to embrace and utilise SPSP work streams as an evidence base for approach to care and to structure service change and measure effectiveness. Within Elderly Mental Health Services a number of senior clinicians have attended specific training re Dementia and particularly with regards to Stress and Distress training; a further programme of in-house training for staff will be delivered later this year.

There are robust Clinical Governance structures in place throughout services all reporting into the Governance and Development Group to ensure a shared approach to learning and a forum for cross service issues to be discussed.

There is an established Adverse Event Reporting Group for pan Ayrshire Mental Health Services who review all mental health related adverse events including unexpected deaths and suicides. The group are responsible for the initial review of all incidents meeting the reportable criteria as per policy and ensure any aspects of learning and /or improvement is identified, shared across the organisation and where relevant, nationally. Aligned to policy and protocol, the AERG escalate any significant events to the Leadership Oversight Group who review all referred cases and commission a Serious Adverse Event Review where relevant. All action plans and outcomes are reported through the relevant governance committees providing assurance of learning and that improved practice is installed and sustained. The arrangements for AERG are being reviewed on an ongoing basis supported by Risk Management Managers to ensure a continuous improvement ethos is applied.

There is ongoing vigilance in assuring that the most efficient use of resources is maximised. This includes review of all vacant posts via a local scrutiny group which takes in to consideration relevant need for the post, impact for filling or rejecting the post application and consideration to diversifying the resource to a more appropriate needs led requirement. Efficient use of resources also brings in to consideration any transformational role development to ensure the needs of our patient group are met with having the right skills and personnel in place. All diversification of clinical resource is discussed via the Clinical Care and Governance Committee to ensure all
views and considerations of clinical impact are explored and supported.

2. Are patient and service users’ perspectives taken into account in the planning and delivery of services?

Mental health inpatient services embrace a collaborative approach to care and positive feedback has recently been received across services from the Mental Welfare Commission as to the quality and person centred nature of care plans. A continued programme of training re carer engagement is ongoing and each ward/team has an identified carer’s champion to provide advice and support to colleagues.

The use of ‘My View’ is encouraged within the electronic clinical record that describes the person’s view as to their health and wellbeing and expectation of contact with services.

3. Do services treat people with dignity and respect?

Protecting the rights of vulnerable individuals who are acutely unwell is a primary consideration for services and is reflected in NHS Ayrshire and Arran’s and local partnerships values. All inpatients in the mental health setting in NHS Ayrshire and Arran’s facilities are now cared for in individual bedrooms with the increased dignity and privacy this affords. Patient’s rights are protected through legislation, compliance with which is audited internally and externally.

As already described a collaborative approach to care is embraced and the use of advance statements is encouraged and, where they exist, taken account of in all decision making processes or entry made into the clinical record if care decisions are being made that do not accord with those in the advance statement and a rationale for why this has required to be undertaken.

The use of enhanced observations is recognised as being intrusive and an invasion of privacy and is used only as a last resort, through consultation with the individual and with a clear rationale provided. Written information is given to the individual and their families as to the purpose of enhanced observations and that this will only be utilised for the least time possible. Within the adult acute inpatient setting there has been a sustained reduction in enhanced observations over the last 14 months.

The organisation take cognisance of all complaints and commendations including measured response to public views through systems such as Patient Opinion. There is an engagement protocol that sits within both the complaints system and through activity from formal reviews of care.

4. Are staff and the public confident about the safety and quality of NHS Services?

There are robust governance structures across all services and the use of
DATIX to report any incident of potential or actual harm. Patient and service user feedback is sought as to their experience of service including a questionnaire at time of discharge from adult acute inpatient services. Complaints processes are well embedded and services will look to have dialogue with complainants to discuss/resolve their concerns at a local level as timeously as possible.

Staff are encouraged to report/escalate any concerns through line management processes and the Whistle Blowing Policy affords protection to employees who raise concerns. Staff have previously completed the Staff Survey that ascertains views as to workload, consultation; how they feel they are treated by the organisation. The iMatter questionnaire has recently been completed which will allow for analysis by individual teams with specific action plans.

Strategic development regarding the service is multi faceted and includes approaches such as consultation events involving public and patient representation groups. We also utilise our expert users by way of the Public Reference Group and formal involvement of the public via our Public Partner Officer.

5. Do quality of care, effectiveness and efficiency drive decision making in the NHS?

Within NHS A&A all the measures as described above drive care, however there is a tension between individualised person centred care and efficiency of fitting people into ‘systems’. As with all public sector services there has been a drive to increase efficiency of services and release monies that can be reinvested in other areas given the constraint on the public purse. To date, increased efficiency and reducing waste has been evident however it is acknowledged with ongoing expectations of further austerity measures that some areas of concern are raised from the clinical perspective. Efficiency drivers also have implications for workforce and consideration is being given to how best ensure safe staffing levels and providing high quality care whilst ensuring the most efficient use of resources. There is also concerted activity to reduce the use of supplementary staff which has both clinical and financial implications.

6. Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?

Processes re risk assessment, incident reporting and complaints have already been described above. Within mental health services the Adverse Event Review Group (AERG) reviews all submitted DATIX within the service of a higher risk outcome nature and ask for further review dependent on severity of actual/potential incident as described earlier in the document.

These systems are well proven with a clear auditable process as to reporting, investigation, review and planned actions with further follow up to ensure any changes to service delivery and/or learning are embedded across the relevant
Learning notes are generated by the AERG for the most significant incidents to ensure they are known across all services.

As part of our developed clinical pathways, we have the ability to recognise variance within our systems. This is done at both clinical levels and via our electronic patient records team. We have the ability to audit performance against expectation of actions such as completed risk assessments. This allows us to thematically address any areas of improvement requirement and inform the assurance aspect of governance when required.

We are developing our clinical supervision framework and promoting better use of clinical supervision to support all clinical staff in reviewing their own clinical activity including where elements of improvement are identified. The organisation takes a supportive view when addressing performance deficit but formal structures are in place to address capability and disciplinary issues.