NHS England

Clinical Governance in Integrated Urgent Guidance for Commissioners

Clinical Governance in Integrated Urgent Care Guidance for Commissioners

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1 Summary

Clinical Governance in NHS Integrated Urgent Care (IUC) Services is based on the fundamental principle that it should take responsibility for the whole patient journey that begins with a call to 111 and ends when the patients' needs have been met. There are particular challenges in providing oversight of a multi-disciplinary clinical hub and the referral of patients outside the Integrated Urgent Care system.
The documents below describe a comprehensive Clinical Governance structure and processes for the newly developed Urgent Care networks to adopt and promote. Together, these constitute a 'system' of clinical governance for Urgent Care Networks. Many of the principles and best practice used in the Clinical Governance of NHS 111 services have informed the development of the guidance in this document.

This central responsibility has fundamental implications for the way in which the clinical governance is structured; it requires the effective involvement of all the partner organisations which together provide IUC services as well as those which interface with it, either as sources, or receivers, of referrals and advice from IUC. This will include Primary Care, Community services, Emergency Departments, mental health services and so on. In other words, all the major providers of urgent and emergency care in a local health community come together to take collective ownership of the safe and effective governance of 'their' local Integrated Urgent Care Service, thereby ensuring that the service is in fact 'fit for purpose' within that particular local health community.

The clinical governance of Out of Hospital services is explicitly designed to facilitate this process, bringing all the relevant providers together around the same governance table, enabling them to start to understand better the nature of the services each provides, to start to build trust and confidence in each other's ability to deliver high quality services and thus to start to work effectively together to remodel and redesign local services in ways which will make a real difference to patient care

2 Clinical Governance

2.1 Introduction

Clinical Governance is a framework 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.

A National Medical Advisor will work closely with 4 Regional IUC CAS Clinical leads aligned with the four PMO regions (North, South, Midlands, London) who in turn will work with and support the local CCG Urgent Care clinical governance lead (see **Appendix A** for suggested job description) and the Lead provider clinical governance lead. A network of Urgent Care clinical leads from represented CCGs should be incorporated to allow dissemination of information and to bring local issues to light.

The regional clinical leads offer both leadership and governance oversight for their individual regions and should be considered as an extension of the NHSE Regional Urgent Care PMO team.

The local leads will be clinicians working within the local health economy, have suitable understanding of the local nuances to provision of care and work closely with local Quality and safety teams.

A general job description and person specification is attached. (**Appendix B**). The personal specification would be the same for both regional and local leads.

The local and regional leads will be responsible for ensuring the return of comprehensive clinical governance reports, reporting of all Significant events (KPI 11) and reports after any End to end review meeting (KPI 12) are forwarded on to the National medical advisor in a timely manner.

All SIs and learning from the E2E meetings will be nationally collated and learning will be shared. It is most important that the local clinical lead when chairing the E2E meetings manages to encourage a transparent culture of sharing and learning in a non-judgemental environment. It is vital to ensure the attendance of all relevant clinicians to promote the importance of these reviews and increased understanding of system wide learning and improvement in any area of urgent care.

Where IUC CAS involves more than one provider it is appreciated that there will be a need to have multiple reports. Every effort should be made to standardise these but should as a minimum include the summary as set out in **Appendix C & D**.

The monthly reports sent to commissioners should be simultaneously sent to the regional clinical lead in order to streamline the national collection of SIs and E2E reports. The data will be collected via the MDS and the quality detail will be aligned via the National medical advisor.

2.2 Key elements

Key elements for local oversight of clinical quality of service provision will include, as a minimum:

- A local IUC CAS Clinical Assurance Group (CAG) or equivalent. The local Urgent Care clinical governance lead will chair this group. The suggested terms of reference and membership attached in **Appendix E**
- All providers which make up IUC CAS have an obligation to report to the IUC CAS CAG irrespective of individual commissioner
- A local reporting structure needs to be put in place for the IUC CAS incorporating all elements from initial telephony to face to face/home visits
- Reporting should allow systematic capture of Incidents (via Datix), Significant Incidents (via STEIS), Complaints and Compliments. (A suggested minimum/style report is shown in **Appendix D**)
- All SIs (involving any provider within the IUC CAS) and associated root cause analysis should be reported on to the Regional Lead for incorporation into the National Learning (SI reporting form/72 hour report immediately and full report incorporating RCA on completion).
- The NHSE guidance on SI reporting can be found here: https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf (Please note it is however due to be refreshed in August 2017).
- Reporting of all staff audits-call handlers/supervisors/clinical staff
- Reporting of all system audits
- *Where IUC CAS involves more than one provider it is appreciated that there will be a need to have multiple reports. Every effort should be made to standardise these but should as a minimum include the summary as set out in **Appendix D**.

2.3 Monthly reports

The monthly reports sent to commissioners should be simultaneously sent to the regional clinical lead in order to streamline the national collection of SIs and E2E reports. The data will be collected via the MDS and the quality detail will be aligned via the National medical advisor.

- Review clinical impact of failed KPIs and liaise closely with the contracting team
- Ensuring robust End to End (E2E) reviews occur regularly with suitable onward reporting and outcomes captured for further learning. (E2E template, **Appendix F**)

- Capturing feedback- patient, staff and local Health Professional feedback in systematic, regular fashion.
- The IUC CAS CAG must ensure all Clinical Decision Support tools/protocols for clinical and non-clinical staff used in the service are evidence based and regularly appropriately updated.
- Encourage participation by all members of the service in Learning and Development initiatives with suitable clinical governance oversight and approval
- Understand the risk management required in the IUC CAS and ensure there is a “blame free” culture within the collaborative service to encourage everyone to report problems and mistakes
- Ensure appropriate education and training for all members of staff. Link to Workforce development information https://www.hee.nhs.uk/our-work/developing-our-workforce/developing-nhs-111-workforce
- Ensure appropriate use of Information and Information technology relating to patients, including requiring patient data to be up to date, used appropriately and confidentiality respected.
- Any CDSS system(s) used within licence
- A clear local governance structure should be developed ultimately reporting to the CCG board. Details should be provided to all represented CCGs.
- As the IUC CAS in an integral enabler for the whole Urgent and Emergency Care local provision the governance structure must also be appropriately linked to other oversight groups focussed on this area of work.

Appendix A - Suggested Job Description: Clinical Lead to IUC CAS

Integrated Urgent Care
Suggested Job Description: Clinical Governance Lead to Integrated Urgent Care Clinical Assessment Service XXX CCG

Job Title: Clinical Lead to IUC CAS
Nominal Location/Base: to be agreed
Responsible to: XXX CCG Board
Fixed Term

Job purpose

The Clinical Lead will work closely with NHS 111 and Urgent Care commissioning teams XXX CCG [locality based] and other local relevant stakeholders to ensure the whole system add value to the urgent care patient pathway. This will include significant clinical and stakeholder engagement work. There will also be a duty to provide a high level of clinical scrutiny to the systems and processes involved to provide peer assurance.

Main responsibilities

- Provide strong clinical leadership and support for IUC CAS and Urgent Care commissioning team
- Undertake clinical engagement with health professionals, GP consortia and relevant stakeholders to ensure wide clinical empowerment
- Provide a healthy challenge for IUC CAS and Urgent Care Systems with the common aim of improving patient care, experience and staff experience
- To be integrally involved in all aspects of IUC CAS and Urgent Care decision making including the scrutiny of the data and clinical outcomes
- To have sufficient organisational and inter-organisational support to be able to assure the quality of the clinical governance of the local IUC CAS service
- Engage with other stakeholders and agencies as appropriate
- Assist and develop the Healthcare professional feedback processes
- Undertake regular and appropriate mentoring and mentorship to ensure a strong individual performance and team relationship
- Provide monthly update via template to regional CG lead

Communications and working relationships

The post holder will be expected to communicate directly and regularly with all key stakeholders including:

* Lead Urgent Care Commissioners

* All involved health professionals

* IUC CAS /Urgent Care teams

* NHS Pathways

* Partner organisations for call handling, transport, urgent care provision

* Public, patients and carers

Personal development and appraisal

The post holder should have equitable access to NHS staff development opportunities and career progression. The post should be appropriately appraised and form part of the post holders annual appraisal.

Clinical and Corporate governance

The post holder will ensure compliance with employer policies, procedures and clinical guidelines.

General

This job description is intended as a guide to the principles duties and responsibilities for the post. Adaptation and evolution will be a necessary characteristic as the programme develops.

Appendix B - Job Description: Regional Clinical Lead

Integrated Urgent Care
Suggested Job Description: xxxxxxx Regional Clinical Lead

Job Title: xxxxxxx IUC Regional Clinical Lead
Nominal Location/Base: to be agreed
Remuneration: Two sessions per week
Responsible to: NHS England IUC Medical Advisor (or REGIONAL NHSE MD?)
Fixed Term

Job Purpose

The IUC Regional Clinical Lead will provide clinical leadership and strategic oversight of the IUC Service in terms of its clinical safety, governance and effectiveness within the xxxxxx Region. Providing assurance on the continual development of robust, safe, and enduring clinical governance processes across each NHS service delivery area.

The role will be hosted by the NHS England xxxxxxx Region and report to the NHS England National Medical Advisor, working alongside the IUC Commissioning Team.

The Regional Clinical Lead will Chair the Regional Quality Assurance Committee with representation from each CCG's Urgent Care Clinical Lead within the area and the IUC CAS Clinical Lead with support from Managerial Lead and the Commissioning Team. To ensure robust feedback and reporting processes are in place and that, feedback systems are operating as intended and that any clinical issues are reviewed and addressed as is required.

At a national level the Clinical Lead will offer clinical expertise in relation to IUC and represent the xxxxxxx Region at regional and national forums as needed. Engaging at a national Level with other Clinical leads and NHS England leads as required; providing regular progress reports to the IUC National Medical Advisor and other stakeholders.

Main Duties

1. To be a member of the National Clinical Leads Group (NCLG) for IUC , acting as a conduit for dissemination of information to clinical colleagues as appropriate
2. Provide strong clinical leadership and support for IUC.
3. To put in place an agreed clinical work plan signed off and monitored via the U&EC Programme Board
4. To chair the XXX IUC Regional Clinical Quality Assurance Committee (CQAC) providing clinical input to all aspects of its activity; ensuring active clinical involvement in all areas relating to IUC, in particular the development of nationally specified, locally commissioned IUC Clinical Assessment Service (hub)
5. To oversee call and End to End review systems

6. To oversee the robust monitoring of all serious incidents, and when appropriate involvement in, or oversight of, any end-to-end or call reviews relating to these incidents.
7. To oversee via the Clinical Leads HPF feedback processes to identify any trends or themes and ensure appropriate action is taken to remedy issues.
8. To ensure links at strategic level to implement clinical change e.g. learning from incidents, DoS and NHS Pathways developments and other high-level impact operational issues.
9. Ensure the dissemination of outputs from the CQAC to relevant stakeholders, especially local Urgent Care Working Groups
10. Provide a healthy challenge for IUC across the Region and of urgent care systems with the common aim of improving patient care, experience and staff experience.
11. Undertake clinical engagement with health professionals and relevant stakeholders to ensure wider clinical engagement with the IUC CAS
12. To support and provide leadership to each individual CCG clinical lead across the region
13. Undertake where required, regular and appropriate mentoring and mentorship to ensure a strong individual performance and team relationship.
14. To develop and participate in IUC education and learning events for CCG clinicians to promote wider understanding and engagement
15. To provide clinical leadership as part of any future re-procurement process
16. To support the National Medical Advisor as may be required
17. To oversee the preparation of all regional clinical reports required by the national team.

Communications and Working Relationships

The post holder will be expected to communicate directly and regularly with all key stakeholders including:

- National Medical Advisor
- xxxxxxx IUC CAS Commissioning Team
- NHS111 CCG Clinical Leads
- Urgent care teams across the region including Networks
- Other key stakeholders as required, including the public
- NHS England Central Team /NHS England Regional Team

Person Specification

- Current unrestricted registration with relevant professional body with experience of working strategically;
- Understanding of, or interest in developing, clinical assessment and management of patients flows;
- Excellent communications skills, preferably with experience in dealing with the media;
- Sound understanding of clinical governance;
- The ability to understand and work in a politically sensitive environment;

- Good leadership skills with the ability to influence and negotiate with tact and diplomacy;
- The ability to analyse complex issues, identify potential solutions and reach sound conclusions;
- Clear commitment to delivering quality and patient focused services

Appraisal

The post should be appropriately appraised and form part of the post holder's annual appraisal.

Clinical and Corporate Governance

The post holder will ensure compliance with employer policies, procedures and clinical guidelines.

General

This job description is intended as a guide to the principle duties and responsibilities for the post. Adaptation and evolution will be an essential characteristic as the programme develops.

Appendix C - Performance report

https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/clinical-governance-guidance-appendix-c-performance-report/at_download/file

Appendix D - Quality report

https://www.networks.nhs.uk/nhs-networks/integrated-urgent-care-delivery/documents/clinical-governance-guidance-appendix-d-quality-report/at_download/file

Essential summary for all reports

- Incidents*
- Complaints*
- HPFs*
- SIs reported
- SIs concluded
- E2E reviews completed

These should be broken down to the following themes:

- Access: any issues relating to the accessibility of services, e.g. delayed answering or call back, hearing problems preventing use of telephony route, telephony problems

- Communication: e.g. language problems, attitude, empathy, advice delivered, “customer care”

- Assessment and Decision Making: issues relating to the human element, e.g. lack of probing, failure to recognise complex call, not acting upon Special Notes, not making use of supporting information and systems like SCR, Toxbase and so on, handover within NHS 111, inappropriate advice from colleague

- Technology: issues relating to the technological side, e.g. Adastra outage, CDSS issues, IT failure, DoS, electronic links to other systems

- Healthcare System: problems with the pathway of care, handover between organisations, lack of referral rights, services not available, delayed response from other provider, business continuity issues

- Safeguarding: to include incidents involving safeguarding concerns

- Other: issues not well captured under the categories above (please provide a short note to elaborate)

Appendix E - Suggested Terms of Reference for IUC CAS

Suggested Terms of Reference for Integrated Urgent care Clinical Assessment Service Clinical Assurance Group (IUC CAS CAG) or equivalent

1. Introduction

These Terms of Reference (ToR) set out the purpose, membership and reporting arrangements for XXX Clinical Commissioning Group IUC CAS Clinical Assurance Group.

2. Purpose

2.1 To ensure robust and measurable systems are evident within the XXX CCG IUC CAS commissioned service incorporating the whole patient pathway for service users accessing the service including the interfaces and relationships with partner providers

2.2 To develop a clinical governance and assurance framework that ensures the delivery of national and local guidance in relation to the IUC CAS service making certain good governance occurs between organisations and details the mechanisms by which the care of patients is safeguarded across the whole patient pathway.

2.3 To provide a forum and facilitate partnership working across the healthcare economy enabling a whole system approach to be adopted in shaping the model of urgent care in XXX CCG

2.4 To review and monitor the arrangements and clinical safety of the Clinical Operational Gateway (COG) access line for professionals

2.5 The group does not replace current forums within partner organisations, but acts to ensure good clinical governance links exist between those organisations.

3. Responsibilities

General

3.1 To establish systems and review key performance indicators for assuring the quality, patient safety and patient experience of the IUC CAS service in relation to identified pathways including the provision of clinical scrutiny and overview of end to end pathways.

3.2 To monitor and review clinical risk management processes including actions taken to mitigate identified risks to ensure that the clinical integrity of the service remains resilient.

3.3 To review business continuity arrangements relating to the provision of IUC CAS services

3.4 To review the recruitment, selection, training and professional development processes for NHS 111 call-takers and clinical advisors. To monitor the ongoing implementation of these training and professional development programmes.

Learning from experience

3.5 To ensure robust processes are in place to recognise, report and investigate serious untoward incidents, complaints, near miss incidents and SUIs in accordance with national guidance.

3.6 To monitor and review action plans in relation to reported patient safety incidents, complaints and feedback from health care professionals ensuring that whole systems' learning is achieved.

3.7 To undertake aggregated analysis of incidents, complaints and feedback to ensure trends and themes identified are subject to action planning and that a programme of continuous quality improvement is put in place.

3.8 Review patient experience through monitoring of IUC CAS PALS information, Friends and family test and provider satisfaction surveys.

3.9 Review patient experience by listening to 111 calls and review of onwards patient journey selected at random, as a result of complaints/incidents and in relation to themes selected by the CAG eg. calls from nursing homes, ambulance non conveyances

Audit and Policy Development

3.10 To agree, monitor and seek assurance of the effectiveness of clinical audit programmes implemented within the IUC CAS commissioned service and across partner agencies to include interfaces of care.

3.11 To, receive, review and disseminate evidence based research and policy documents relevant to the IUC CAS service.

3.12 To develop, review and agree policies, protocols and guidelines, in light of local and national guidance, to ensure a safe patient pathway for patients using the IUC CAS service.

4. Membership

4.1 The membership is set out below.

4.2 Other stakeholders may be invited to attend for specific items with the prior agreement of the Chair. This might also include representatives from independent contractors, community dental and optometry services.

5. Quorum

5.1 The Committee is quorate when four members are present. If such a quorum is not present within 15 minutes of the appointed time or if during the meeting ceases to be present, the meeting will stand adjourned.

6. Frequency of Meetings

6.1 Meetings shall be held monthly or otherwise as indicated by the programme and/or progress of work.

7. Conduct of Meetings

7.1 All questions arising will be decided by a simple majority of those present. In the case of equality of votes, the Chair will have a casting vote.

7.2 Minutes shall be kept and the Secretary shall record the proceedings and resolutions.

7.3 Agendas will normally be issued at least seven days prior to the meeting. Requests for items to be included on the agenda should be sent to the Chair at least ten days before the meeting.

7.4 Should an item need to be raised on the day, this can be covered under ‘Any Other Business’, subject to there being available time.

7.5 If separate papers require circulation, these should, wherever possible, be issued with the agenda. This is intended to enable the members to have the opportunity to read information in advance.

7.6 Notes from meetings will be produced and issued by the Chair or nominated deputy. These will normally be circulated within 14 days listing topics discussed and actions agreed and individuals responsible for undertaking those actions. All actions to be completed within the agreed time frame.

7.7 An extraordinary meeting may be summoned by the Chair with five working days’ notice.

7.8 Meetings will be called and conducted in accordance with Standing Orders.

7.9 Minutes of the meeting will be formally recorded and submitted to the XXXX Programme Board.

8. Standing Agenda Items

8.1 Minutes and Actions from previous meetings

8.2 Review of complaints and Serious Incidents

8.3 Review of selected calls to 111 and onwards patient journey (unless covered in separate meeting)

8.4 Review of Clinical Risk Register (5 Stage Review Spreadsheet)

8.5 Safeguarding issues

9. Reporting Arrangements and Relationships

9.1 The IUC CAS Clinical Assurance Committee will report monthly by submissions of minutes to the XXX Programme Board

9.2 Quarterly reports will be sent to the Clinical Commissioning Groups, or more frequently by exception.

9.3 The local Clinical Lead will work closely with the Regional PMO Clinical Lead and report back to the IUC CAS CAG as appropriate

10. Dissolution

10.1 XXX CCG Board can amend, change or dissolve the Committee, in accordance with Standing Orders.

11. Limitation of Authority

11.1 Save as is expressly provided in the Terms of Reference, the IUC CAS Assurance Group shall have no further power or authority to exercise on behalf of the XXX CCG any of its functions or duties.

12. Review

12.1 These Terms of Reference will be reviewed in annually. Under such circumstances a full amended copy will be circulated to the members of the XXX CCG Board

Membership
The core membership of the XXX Clinical Governance (CG) Group includes the following:

- Local IUC CAS Clinical Lead (Chair)
- Commissioning Lead
- CCG or CSU Clinical Governance/ Quality Lead
- Provider Operations Lead
- Provider IUC CAS Clinical Lead
- Provider Clinical Governance Lead
- Provider GP Director

- Patient Representatives (X2)
- Local Medical Committee (LMC) Representative
- Ambulance Trust Representative
- DoS lead

If different to IUC CAS telephony provider:

- Face to face provider(s) Clinical Lead
- Face to face provider(s) operations lead

The above regularly attend, in addition depending on the issues under discussion we have asked others to attend on an ad hoc basis, these include:

- ED Representatives
- Other local GPs
- Mental Health Trust Representative
- Community Health Services Representative
- Voluntary Sector representatives
- Other CCG representatives

Appendix F - End to end review template

Integrated Urgent Care – End to End Call Review Template

Integrated Urgent Care – End to End Call Review		
Call Review Date:		
Call Theme:		
Date of Call:		
Time of Call:		
Total Length of Call:	**111 Call Length:**	**Clinician Call Length:**
Age of Patient:		
Gender of Patient:		
111 Case Reference:		
IUC CAS Case Reference:		
999 Case Reference:		
UCC Case Reference:		
Patient Journey NON-CLINICAL		
Reason for the call:		
Pathway used by NHS 111 Health Advisor (Non-Clinical):	**Pathway Used:**	**Appropriate Pathway Y/N:**
Disposition Reached (Dx Code and description):		
Was Disposition Accepted by		

patient: Y/N			
Care / Worsening advice given: Y/N			
Service the patient was directed to:	**Service:**	**ITK link sent: Y/N**	**Directly booked appointment: Y/N**
Patient Journey CLINICAL			
Pathway used by NHS 111 Clinical Advisor:			
Advice given by the 111 Clinical Advisor:			
Did the 111 clinical advice add value to the patients journey: Y/N			
If NO reasons why (e.g. didn't work autonomously outside of NHS Pathways):			
111 Clinician disposition reached (Dx code):			
Was the disposition accepted by patient: Y/N			
Care / Worsening advice given: Y/N			
Service the patient was referred to:			
Did the patient speak to IUC			

CAS: Y/N	
Advice given by the IUC CAS Clinician:	
Did the patient have an onward referral? Y/N if YES what service was the patient referred to:	
Was the patient treated at the UCC: Y/N	
If YES – What was the outcome:	
Was an ambulance sent to the patient: Y/N	
If YES was the ambulance appropriate: Y/N	
Was the patient conveyed to ED: Y/N	
Was the conveyance appropriate: Y/N	
What advice was given by the crew (Non-Conveyance only):	
If conveyed was the patient admitted: Y/N	

In-patient summary: RAIDR OUTCOME	
Learning from Call Review	
Did the group feel that the patient could have had a better journey through the system: Y/N If YES what recommendations were made?	