**East Lothian Health & Social Care Partnership**

**Clinical and Care Governance Framework**

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**Clinical & Care Governance Framework**

1. **Introduction**

The main purpose of the integration of Health, Social Work and Social Care services in Scotland is to improve the wellbeing of people who use such services, in particular those whose needs are complex and require services and support from Health and Social Care at the same time. Integration is intended to achieve improved outcomes for people in line with the National Health and Wellbeing Outcomes (Appendix 1) prescribed by Scottish Ministers in Regulations under Section 5 (1) of the Public Bodies (Joint Working)(Scotland) Act 2014.

The National Health and Wellbeing outcomes apply across all integrated Health and Social Care service, ensuring that Health Boards, Local Authorities and Integration Authorities are clear about their shared priorities by bringing together responsibility and accountability for their delivery. These outcomes, together with the integration planning and delivery principles, are grounded in a human rights based and social justice approach.

This Clinical & Care Governance Framework for East Lothian has been developed to ensure that there are explicit and effective lines of accountability across Health and Social Care as part of the integration scheme. It builds on systems and processes already in place and functioning well whilst developing new ways of gathering and reviewing service data that supports good governance. It sets out the assurance arrangements that will be put in place to ensure high standards of care and professionalism in the services provided throughout East Lothian in relation to:

* Delivery of **Person Centred** services - learning from feedback and complaints, acknowledging the Heath and Social Care Standards – My Support, My Life 2017.
* **Safety** – services / pathways are evidence based and risks are well managed.
* **Effective** - meeting clinical / care and public health standards through local evaluation and external scrutiny and service review.
* **Professional development** - ensuring staff have access to training to maintain and develop skills / competencies.
* **Improvement** - ensuring that we have the capacity, capability and leadership to develop and redesign services and recognise the need for improvement.
* **Shared Learning** – provide support and resources to ensure that any learning from adverse events / incidents are shared across the organisation.
* **Escalation Process** – ensuring that there is a robust and widely known process through which staff, patients and service users can raise concerns.

This Governance Framework outlines the roles, function and focus regarding care delivery and professional governance for the range of staff / professionals involved with the planning and delivery of integrated health and social care services within East Lothian. This framework will evolve in the light of experience with joint working and local requirements for service development. Oversight of the assurance process will be the remit of the East Lothian Clinical & Care Governance Committee (CCGC) established in July 2018. (See Appendix 2 Terms of Reference)

1. **What is clinical and care governance?**

A National Framework for Clinical and Care Governance was developed in 2015 and defines clinical and care governance as *‘the process by which accountability for the quality of health and social care is monitored and assured’* creating a culture where delivery of the highest quality of care and support is understood to be the responsibility of everyone working in the organisation – built upon partnership and collaboration within teams and between health and social care professionals and managers. It is the way by which structures and processes assure Integration Joint Boards, Health Boards and Local Authorities that this is happening whilst at the same time empowering clinical and care staff to contribute to the improvement of quality and making sure that there is a strong voice of the people and communities who use services.

The ‘National Framework’ in 2014 identified five key principles of clinical and care governance (see below) and five process steps to support clinical and care governance (see Appendix 3):

1. Clearly defined governance functions and roles are performed effectively.
2. Values of openness and accountability are promoted and demonstrated through actions.
3. Informed and transparent decisions are taken to ensure continuous quality improvement.
4. Staff are supported and developed.
5. All actions are focused on the provision of high quality, safe, effective and person-centred services.

Clinical and care governance is composed of the following elements:

* Safe and effective practice & care
* Person centred practice & care
* Responsibility and accountability
* Capacity and capability
* Team work
* Service user experience

All aspects of governance are set within the context of the legal and strategic aims of The Scheme of Integration for the Integration Joint Board (IJB) May 2015 along with the Strategic Plan 2016/19 and the directions set by the IJB.

Clinical and care governance including professional governance for the health and social care services provided in East Lothian will be monitored through the governance and assurance process developed by the CCGC (see Appendix 4, Governance and Assurance Process). This framework has been jointly developed through consideration of the existing governance arrangements of the key parties, namely East Lothian Council and NHS Lothian Health Board and acknowledges the standards and requirements of other relevant bodies e.g. The Care Inspectorate and Healthcare Improvement Scotland (HIS).

1. **What is Professional Governance?**

Professional governance is an accountability framework that empowers Health and Social Care professionals at the front line to collaborate effectively in the delivery of services. Central to this is the creation of an environment which enables practitioners to:

* Practice in accordance with their professional standards, codes of conduct and organisational values.
* Be responsible for upholding professional and ethical standards in their practice and for continuous development and learning that should be applied to the benefit of the public.
* Ensure the best possible care and treatment experience for service users and families.
* Provide accurate information on quality of care and highlight areas of concern and risk as required.
* Work in partnership with management, service users and carers and other key stakeholders in the designing, monitoring and improvement of the quality of care and services.
* Speak up when they see practice that endangers the safety of patients, service users or staff in line with local whistle-blowing policy and regulatory requirements.
* Engage with colleagues, service users, communities and partners to ensure that local needs and expectations for safe and high quality health and care services, improved wellbeing and wider outcomes are being met.

The overarching Governance Framework along with associated policies, procedures and systems will provide assurance to the Integration Joint Board, East Lothian Council, Lothian Health Board, the public and service users that effective processes for Health and Social Care practice are in place and implemented to develop, support and monitor care standards within agreed accountability and governance frameworks.

**Professional Lead Officers**

There are statutory functions (set out by the Scottish Government Directorate for Health and Social Care) relating to the assurance that professional standards are maintained. The Professional Lead Officers for the East Lothian Health and Social Care Partnership will provide professional advice to, or raise issues directly with the IJB or through representatives on the IJB. In addition, the Professional Lead Officers will be responsible for reporting directly to the Council or Health Board.

The professional lead officers are -

* Chief Social Work Officer
* Clinical Director
* Chief Nurse

These individuals have a specific remit for ensuring that professional assurance arrangements are in place, are effective and appropriately monitored. This Governance Framework for all Health and Social Care professions working across the services in East Lothian has been developed to reflect the lines of accountability within the joint working arrangements across the health and social care services. The lines of accountability will be assured through the reporting of activity to the CCGC.

In addition, the CCGC will seek to ensure that the principles and standards of clinical and care governance are applied to the health improvement and health protection activities of the Partnership and that appropriate mechanisms are in place for the effective engagement of representatives of patients, clinical staff and other professionals in clinical, care and professional governance activities.

The CCGC will have representation from key professional groups. These individuals will support the development of the work of the CCGC and will contribute to the monitoring and assurance process.

Committee Membership:

* Medicine
* Nursing
* Social Work
* Allied Health Professions (AHP)
* Integration Joint Board (IJB)
* Communications
* Health Care Planning
* Public Protection
* Public / Carer Representation
* Others as required

1. **Accountabilities for Clinical and Care Governance**

The Health Board and Council (the Parties) have existing mechanisms to demonstrate accountability to the Scottish Government and the public. The Integration Joint Board will integrate new and existing methods of professional performance management and governance. This will include arrangements for the protection of people of all ages, as well as strategic planning and community planning across East Lothian.

The Accountable Officers are:

**Chief Executives**

The Chief Executive Officers of the Council and the Health Board hold ultimate accountability for the delivery of clinical, care and professional governance.

**Chief Officer of the Integration Joint Board**

The Chief Officer manages the integrated services of the Integration Scheme and is accountable for this through the Parties Chief Executives. The Chief Officer is accountable for the care standards and safe delivery of these services, for example, ensuring that they are person centred, effective and delivered to agreed clinical and care governance standards. The CCGC will act as the scrutiny mechanism to provide this assurance to the Chief Officer.

The management framework for operational delivery of the integrated services via the Chief Officer is through a single hierarchical management structure.

The Chief Officer reports directly to both the Chief Executive of the Council and the Chief Executive of the Health Board and is a full member of the senior management teams of both the Council and the Health Board.

Working alongside the Chief Officer, the parties will ensure that all staff working in integrated services have the necessary skills and knowledge to deliver the appropriate standards of care. Managers of Health Board and Council staff will promote best practice and cohesive working, and provide guidance and development to their teams. This will include effective staff supervision and implementation of staff support policies.

**The Chief Social Work Officer (CSWO)**

The CSWO holds professional and operational accountability for the delivery of safe and innovative social work and social care services in East Lothian. The CSWO will provide professional advice to the Council and the Integration Joint Board, in respect of the delivery of social work and social care services by Council staff and commissioned care providers in the Integration Joint Board.

**Clinical Director**

The Clinical Director is professionally accountable for the quality of the medical services provided by the IJB (including those commissioned by the IJB).

**Chief Nurse**

The Chief Nurse is professionally accountable for the quality of the nursing, midwifery and AHP services provided in East Lothian. The Chief Nurse will provide professional advice to the Health Board and the Integration Joint Board (IJB) to ensure that nursing, midwifery and AHP services are safe, effective and person centred. The Chief Nurse has a specific remit for ensuring that there is patient engagement in the development of services, that clinical and care standards are met and that validated workforce planning tools are used to underpin workforce and skill mix model development.

The Chief Officer and the Professional Leads will liaise regularly to ensure that their respective roles in relation to professional standards are met.

1. **Related Governance (Assurance) Groups and Forums within East Lothian**

There are a number of groups and forums within East Lothian who are operationally responsible for monitoring local activities inclusive of Care at Home e.g. health and safety, resilience, care homes, public protection, unexpected deaths - adults and children. These groups will provide regular reports to the CCGC ensuring that this core assurance group is kept abreast of activity, changes and concerns. (see Appendix 4)

In addition to the Group Service Managers, representatives from the Public Protection team, Health and Safety, the GP Quality clusters and others will be invited to attend the CCGC to present the work of their service and to highlight good practice, innovation and areas of risk or concern.

1. **Internal Monitoring and Self Evaluation**

Having quality information about the outcomes and impacts being achieved can help an organisation to better understand the needs of the people using the service and its staff. Self-evaluation contributes to continuous quality improvement by providing a structured opportunity to assess performance, and based on this, identify opportunities for improvement. Regular self-evaluation forms part of good internal governance and is a key driver for local improvement work. Quality improvement on the basis of self-evaluation, rather than that which is solely mandated by external agencies can inspire greater local ownership of issues and design of more effective solutions.

Staff throughout the organisation currently collect and discuss data relevant to their service area and this will continue. Each Group Service Manager will set up a process whereby they will meet and discuss on a regular basis their service activity, performance and outcomes. This assurance activity will be routine through the governance and assurance processes (see Appendix 4)

1. **External Evaluation & Inspection**

Inspection, audit and evaluation all play an active role in determining whether or not a service is meeting their key requirements and delivering care and treatment in a safe, effective and person centred way. A number of external scrutiny bodies have worked with the East Lothian Partnership in the past and will continue to work with the organisation in the monitoring of services. The Joint Inspection of Adult Services by the Care Inspectorate and Healthcare Improvement Scotland is one such ongoing external quality assurance process.

Through internal self-evaluation, reporting and monitoring and independent validation through external scrutiny regimes, the organisation will be able to provide public assurance and demonstrate its accountability in action. The outputs from these activities will identify where things could be improved and will inform and drive good and innovative practice.

In December 2017, Healthcare Improvement Scotland published its draft ‘[Quality of Care Approach’](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach/overview.aspx), September 2018, which echoes the principles of the European Foundation of Quality Management (EFQM) model shifting the focus from quality assurance being “done to” organisations to an approach where quality assurance and resultant “intervention” is “done with” them. Open and honest organisational self-evaluation is fundamental to the approach. The [Quality Framework](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach/quality_framework.aspx), How Good Is Your Council (HGIYC) and the Self Evaluation Framework Improvement to Excellence (SELFIE) are tools that have been designed to support self-evaluation for local reflection, evaluation and decision making about how best to improve outcomes for users of services, and also provide external quality assurance activity. All these tools follow a common structure to the frameworks used by external quality assurance partners in social care, local authorities and education. Using a common language and structure across agencies can help reduce the burden of external quality assurance activity by making it easier to see where data and information collected for one purpose can usefully inform another. (See Appendix 4b for an overview of the Quality framework domains and Appendix 4c – Draft Care Inspectorate Quality Indicators 18 / 19).

1. **References**

The following documents have been considered in the development of this framework -

* Public Bodies (Joint working )(Scotland) Act 2014
* The Scheme of Integration for the Integration Joint Board – May 2015
* My Support, My Life – 2017
* East Lothian IJB Strategic Plan – 2016 / 2019
* East Lothian Integration Joint Board Final Integration Scheme – May 2015
* The National Framework for Clinical and Care Governance – December 2015
* Clinical Care and Professional Governance – A Framework NHS Shetland 2016
* Health and Social Care Standards – My Support – My Life – 2017
* Quality of Care Approach / Framework – NHS Healthcare Improvement Scotland – Draft December 2017 & Final Report September 2018
* Care Inspectorate – Draft Quality Improvement Framework Version 4 – March 2018
* Care Inspectorate – A Quality Framework for Care Homes and Older people – July 2018
* Health and Sports Committee ‘The Governance of the NHS in Scotland’ – July 2018
* Adult Support and Protection Code of Practice 2008 – Revision 2014
* European Foundation of Quality Management model - <http://www.qualityscotland.co.uk/content/efqm-excellence-model>
* East Lothian IJB Strategic Plan – 2016 / 2019

**Appendices:**

Appendix 1: National Health and Wellbeing Outcomes under Health and Social Care Integration

Appendix 2: Terms of Reference of the CCGC Committee

Appendix 3: Five Process Steps to Support Clinical and Care Governance

Appendix 4: Governance & Assurance Process: A Suite of Documents

Appendix 5: Acronyms and Glossary of Terms

**Appendix 1**

**National Health and Wellbeing Outcomes under Health and Social Care Integration**

The National Health and Wellbeing Outcomes are high-level statements of what Health and Social Care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across Health and Social Care.

By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

|  |  |
| --- | --- |
| **Outcome 1** | People are able to look after and improve their own health  and wellbeing and live in good health for longer. |
| **Outcome 2** | People, who are frail, including those with disabilities or long term conditions, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. |
| **Outcome 3** | People who use health and social care services have positive experiences of those services, and have their dignity respected. |
| **Outcome 4** | Health and Social Care services are centred on helping to maintain  or improve the quality of life of people who use those services. |
| **Outcome 5** | Health and Social Care services contribute to reducing  Health inequalities. |
| **Outcome 6** | People who provide unpaid care are supported to look after  their own health and wellbeing, including to reduce any  negative impact of their caring role on their own health and  well-being. |
| **Outcome 7** | People using Health and Social Care services feel engaged with  the work they do and are supported to continuously improve  the information, support, care and treatment they provide. |
| **Outcome 8** | People who work in Health and Social Care services feel  engaged with the work they do and are supported to  continuously improve the information, support, care and  treatment they provide. |
| **Outcome 9** | Resources are used effectively and efficiently in the provision  of Health and Social Care services. |

**Appendix 2**

**East Lothian Health and Social Care Partnership**

**Clinical and Care Governance Committee**

**Terms of Reference**

The following terms of reference sets out the membership, remit, responsibilities and reporting arrangements for this subcommittee of the Integration Joint Board (IJB).

**Purpose / Role of Committee**

The Committee will act to review and assure the East Lothian IJB, NHS Lothian, East Lothian Council, Service Users and General Public in relation to the quality of care service delivery and user experience, demonstrating that those systems in place provide early recognition of issues which ensures that appropriate action is taken.

* 1. **Membership**
* IJB representative (Chair)
* IJB representation x 2 to include Public / Carer
* Chief Nurse (depute chair)
* Clinical Director
* Chief Social Work Officer
* Lead AHP
* Manager East and Midlothian Public Protection Team
* Deputy Chief Nurse
* Heads of Service
* Strategic Group Manager

**In attendance as required**

* Administrative support
* Service Group Managers
* Communications
* GP quality cluster representation
* Service Quality & Scrutiny Groups ( Chair) e.g. Health and Safety
* Partnership
* Others as determined by agenda

**Quorum**

The Committee will be considered quorate if the Chair and / or deputy plus 4 members are in attendance.

**2. Remit and Responsibilities**

**Clinical Effectiveness**

The Committee is responsible for overseeing clinical & care governance and quality assurance processes across the Partnership including Professional regulation. The committee will assure the IJB, NHS Lothian and East Lothian Council that all activity relating to health and social care provision meets requirements, inclusive of pre determined standards and legislation. The Committee will develop, implement and maintain an organisation–wide process for clinical and care governance.

The Committee will receive and review data / information relating to:

* Significant Adverse events (SAE) and Large Scale Inquiries (LSI)
* Complaints and concerns
* Public protection
* Medication and other care / service related incidents
* Whistle-blowing as it relates to clinical and care issues

Inclusive of trends themes and outcomes from:

* Investigations of Unexpected deaths (adult and children)
* Independent and local audit and Inspection e.g. Quality of Care
* Other clinical and care governance issues (inclusive of external scrutiny)

In addition the Committee members will:

* Review the impact and lessons learned from adverse events and implement improvement across the organisation and follow up on outstanding action plans.
* Ensure that robust public protection / Adults and Children at Risk from Harm arrangements are in place and in use.
* Ensure that robust systems are in place for the implementation of all aspects of ‘Duty of Candour’ and any reporting requirements.
* Review any circumstance / situation that place the integrity of the Partnership / IJB / service users at risk.
* Ensure that governance systems are robust and that policies and procedures applied to service activities are regularly reviewed and updated as required and in response to concerns and or new legislation.
* Consider issues of concern raised by staff where they believe that patients / service users care or staff well being is compromised.
* Approve Clinical and care Governance reports and associated papers being circulated outwith the Partnership.

**Patient / Service User Safety**

* Receive and review regular reports from all related governance groups confirming that actions have been taken and lessons have been learned.
* Consider the impact of strategic plans on patient / service user safety and care delivery ensuring concerns are addressed
* Consider the risk / implications of proposed new innovations and ensure any concerns are addressed

**Service User Experience and Engagement**

The Committee will seek to ensure that wherever possible the views of the public are taken in to account in the planning and delivery of service. This will include the perspective of patients, carers, relatives and wider service users and will include:

* Review and approval of planned public / stakeholder related events
* Receiving and reviewing outcome feedback from engagement / stakeholder events
* Ensuring that lessons are being learned from service user feedback / intelligence

1. **Responsibilities of Committee Members**

Members of the Committee have a responsibility to:

* Attend meetings having read all circulated papers in advance
* Identify any additional agenda items at least 15 days in advance of meeting
* Submit papers and prepared questions for circulation at least 10 days in advance of meeting
* Act as champions and disseminate information and good practice as appropriate
* Uphold the principles of the relevant Codes of Practice for the NHS, Social Services and respective Professional groups.
* Identify a named representative to attend during any absence in attendance

1. **Frequency of Meetings**

Monthly

1. **Reporting**

The Committee will provide regular reports (quarterly) to the IJB and as required to NHS Lothian and East Lothian Council and in addition will provide an Annual report to all parties.

1. **Administrative Arrangements**

The Committee will be administrated by an appropriate individual who will be responsible for supporting the Chair and Deputy in the management of the Committee business. Responsibilities will include:

* Ensuring an accurate note of the meeting is recorded and disseminated
* Keeping an action log of required outcomes, sharing and monitoring as required
* Circulating agenda and accompanying papers 5 working days before of the meeting
* Filing all related papers in accordance with policy and procedure

NB - There may be occasion where information requires to be discussed in a private session due to its sensitive nature. Where this is a requirement, any recorded detail may be subject to redaction.

1. **Date and review**

These terms of reference were approved by the East Lothian IJB in August 2018 and will be reviewed every 6 months thereafter.

**August 2018**

**Appendix 3**

**Five Process Steps to Support Clinical and Care Governance**

The five process steps to support clinical and care governance as outlined in the Health and Social Care Integration, Public Bodies (Joint Working) (Scotland) Act 2014 – Clinical and Care Governance Framework (The Scottish Government) document are:

1. Information on the safety and quality of care is received.
2. Information is scrutinised to identify areas of action.
3. Actions arising from scrutiny and review of information are documented.
4. The impact of actions is monitored, measured and reported.
5. Information on impact is reported against agreed priorities.

Information of Quality of Care is collected

Information is interpreted to Identify Areas for Action

Information on Impact is reported against Priorities

The Impact of Actions is Monitored, Measured and Reported

Actions Arising from Review of Information are documented

**Appendix 4**

**East Lothian Health and Social Care Partnership**

**Governance and Assurance process**

The IJB have a legal requirement to have overview of the activity and Governance arrangements in place for their Partnership.

These arrangements will include an assurance that there is a robust system which monitors and reports on clinical and care governance matters inclusive of Professional accountabilities and regulatory requirements.

On behalf of the Chief Operating Officer the Clinical and Care Governance Committee (CCGC) is accountable and responsible for giving assurance on all related matters, these having been devolved from the Chief Operating Officer to the Professional Leads, the Clinical Director and the Committee.

The following information and suite of documents Appendices 4A – 4J provides the governance and assurance framework through which each service will report and provide assurance on their performance, professional regulation requirements and all other related aspects of clinical and care governance.

**The Process**

Each Service area / unit should develop a Service Governance profile (Appendix 4A). This profile should be a self evaluation outlining the core service function and local / professional requirements.

The profile should be a ‘live’ document, used regularly by local staff to monitor where the service is in relation to their progress against agreed service aims, objectives and required outcomes. It should detail any agreed improvements and highlight good practice for sharing. Importantly it should provide specific information on the evidence available to demonstrate that the service is delivering its stated aims.

A Guidance document (Appendix 4b) has been provided to support the compilation of this profile.

Group Service Managers should, in discussion with their teams, agree the frequency by which the local profile is updated but, at minimum, should be twice a year. This regular review will support and enable continual self evaluation of the service as outlined in the domains of Health Care Improvement Scotland’s ‘Quality of Care approach and Quality Framework and the Care Inspectorates, key quality Indicator Framework (Appendices 4c & 4d, see also Sections 6 and 7 of the Framework).

Each service area should develop a process of local monitoring whereby the Service Manager regularly and formally meets with their staff (suggest 4-6 weekly) to discuss local activity, performance and any clinical or care governance issue.

In addition, each service area on a daily / weekly basis should review their service performance through informal means e.g. Daily Huddles, escalating any concerns as required.

The Service Managers should, in turn, meet regularly with their Group Service Manager to agree any required action / escalation and or ongoing monitoring.

This process demonstrated in the Assurance Pyramid (Appendix 4e) is supported through the completion of the Monthly Assurance report (Appendix 4f). This report is an operational update of service activity and will enable the service area to highlight success, risks, and concerns.

The Group Service Managers will collate all available service reports to a summary document (Appendix 4g) for submission on a monthly basis to the Committee.

Members of the CCGC will consider all information made available to them and seek to determine whether action is required from individuals, the service, the Partnership or the IJB. This may include seeking an outline of required activity, resource and expected timeline for improvement / completion. Any such requirement will remain on the agenda of the committee until considered complete.

The CCGC will consider any existing or identified potential clinical or care risk. These risks may not be supported with tangible evidence initially; however staff may be sufficiently concerned regarding the potential impact on service delivery and direct clinical and care quality. Escalated risks of any nature which are brought to the CCGC’s attention will be reviewed. The CCGC will seek to mitigate / identify a solution and or respond as required.

The CCGC will also receive and review reports from related assurance / governance groups and prepare as required regular assurance reports and accounts for the IJB, the Health Board and the Council.

The Committee will function within a pre determined schedule and agenda (Appendices 4h and 4I) which includes regular opportunities for service areas to present. During these presentations the service area will be given the opportunity to identify their successes, ongoing improvements and challenges.

The dialogue and feedback from these regular sessions will enable two way discussions up and down the service levels of management and governance. Through this process all aspects of clinical and care governance across the Partnership will be explored and assurances enabled.

This governance framework and assurance process will evolve over time and will be supported through many levels of interaction inclusive of arrangements already in place that sees the reporting of information at several levels which will be illustrated in the future Appendix J which is still in development as at November 2018.

Guidance and support will be given in the initial stages of implementation and where challenge persists.

**Appendices**

4a = Service Governance Profile

4b = Guidance Document

4c = Quality of Care Approach: Domains

4d = Care Inspectorate Quality Indicators

4e = Assurance Process Pyramid

4f = Monthly Assurance Report

4g = Group Service Managers Monthly Summary Report

4h = Committee (CCGC) Reporting Schedule

4i = CCGC – Reporting Calendar

4j = Group / Service Presentation Template

4k = Escalation and Governance Schematic – to be developed in the future (as at November 2018)

**Appendix 4a:**

**SERVICE GOVERNANCE PROFILE**

**Each service unit is required to compile an online Service Governance Profile. This profile should be developed in conjunction with key staff who are involved in the delivery of the service guidance. You may wish to print this guidance off.**

**This profile should be used to self evaluate your IN YEAR service position in relation to Service and Organisational objectives.**

**A copy of your completed service profile should be sent to your Service Manager.**

|  |  |
| --- | --- |
| **SERVICE AREA** |  |
| **LINE MANAGER** |  |
| **GROUP SERVICE MANAGER** |  |
| **DATE OF INITIAL PROFILE COMPILATION** |  |
| **REVIEW DATE 1** |  |
| **REVIEW DATE 2** |  |

**You should review and update your profile in discussion with key staff at least twice a year.**

**See the Guidance Note which has been prepared to assist you in preparing your profile. You may wish to print this off and keep it handy for future reference.**

|  |  |
| --- | --- |
| **OUTLINE OF SERVICE** | |
| **1. THE AIM OF THE SERVICE** |  |
| **2. ORGANISATIONS INVOLVED IN SERVICE DELIVERY (e.g. – NHS, Council, other)** |  |
| **3. KEY ORGANISTIONAL OBJECTIVES RELATING TO THE SERVICE – link to Service Plan** |  |
| **4. KEY SERVICE OBJECTIVES / PERFORMANCE MEASURES** |  |
| **5. OUTLINE FUNDING ALLOCATION FOR SUPPLIES AND WORKFORCE** |  |

The following sections, when completed, should reflect your IN YEAR service position highlighting areas where action is required to improve service delivery and / or service user outcomes.

Each section has been developed taking account of the Health Care Improvement Scotland (HIS) Quality of Care Framework September 2018 and the Care Inspectorates draft Quality Indicator Framework 18 / 19 and the 2017 Health and Social Care Standards.

A RAG model is being used to help you identify, at a glance, where you are doing well and where there are areas that require improvement.

**RAG Legend**

**R – RED – Significant weakness for current and future service delivery / requires urgent action**

**A – AMBER – A weakness for current and future service delivery has been identified / a plan of action is required.**

**G - GREEN – Service delivery is as planned. No plan of action required.**

|  |  |  |
| --- | --- | --- |
| **Section A – KEY ORGANISATIONAL / SERVICE OUTCOMES** | | |
|  |  | **RAG** |
| **Fulfilment of Statutory Duties** |  |  |
| How compliant is the service in meeting requirements |  |  |
| What is your evidence? |  |  |
| **Workforce** |  |  |
| Recruitment and Retention |  |  |
| How effective is your workforce planning? |  |  |
| Do you have a high turnover / vacancy level? |  |  |
| Are you able to effectively recruit? |  |  |
| Do you have stability within your staffing? |  |  |
| What is the age profile of your staff? |  |  |
| Attendance |  |  |
| Do you have an in-year target? If so, what is your plan of action to achieve this |  |  |
| Do you have any sickness / absence issues (short and long term)? |  |  |
| How do you monitor and manage attendance? |  |  |
| If there is a need for improvement do you have an in-year target? If so, what is it? |  |  |
| Staff Deployment |  |  |
| How effective are your processes for staff deployment? |  |  |
| Do your staffing level / skill mix meet service / service user requirements? |  |  |
| If improvements are required what action is being taken? |  |  |
| **Cost Effectiveness** |  |  |
| What efficiency challenges have been identified this year? |  |  |
| What are the agreed in-year efficiency targets (savings to be made)? |  |  |
| What actions are in place to achieve this? |  |  |
| **Learning from adverse events** |  |  |
| Do you have a system in place to report / escalate / monitor and manage adverse events / complaints? |  |  |
| How do you disseminate required actions / shared learning outcomes? |  |  |
| What evidence do you have which demonstrates improvements from learning after adverse events / complaints? |  |  |
| **Collaborating with others** |  |  |
| Do you have a process in place which allows collaborative working? |  |  |
| What evidence can you share where collaborative working has improved outcomes for the service or the service user? |  |  |

|  |  |  |
| --- | --- | --- |
| **B – QUALITY OF CARE / SERVICE DELIVERY** | | |
| **Meeting People’s Needs** |  | **RAG** |
| How do you identify and ensure that people’s needs / service requirements are identified and are correct? |  |  |
| Do you have a system in place which can assure this? |  |  |
| Assessments and care plans should reflect user requirements / choice. How do you ensure this happens? |  |  |
| How do you evidence that care / treatment / support are compassionate, respectful and dignified? |  |  |
| Do you monitor service provision and service user outcomes? If so, describe. |  |  |
| **Involving people in their care / service needs / requirements** |  |  |
| How do you involve service users, carers, significant others in determining their current and future care and service needs? |  |  |
| **Service User Information** |  |  |
| Do you have up to date and appropriate service information available? |  |  |
| Do you have up to date treatment information available? |  |  |
| **Using Feedback for improvement (Service user, carer, family, staff, etc)** |  |  |
| Are systems in place? How do you evaluate? |  |  |
| What activities are ongoing? How do you evaluate? |  |  |
| **Inspection and Audit (internal audit and external scrutiny)** |  |  |
| What takes place locally – what is normal for your service? |  |  |
| What key requirements for improvement have been identified? |  |  |
| Are there any local Action Plans in place and how are these monitored and updated? |  |  |
| How do you ensure all staff are involved / aware of key requirements? |  |  |
| Are there any local audits ongoing as a result of an adverse event or complaint? If so, explain |  |  |
| What National and Local Standards apply to your service and how do you monitor implementation and achievement of these? |  |  |

|  |  |  |
| --- | --- | --- |
| **C- POLICIES, PLANNING AND GOVERNANCE FOR CARE DELIVERY** | | |
| **Policy and SOP’s** |  | **RAG** |
| Describe your communication arrangements for ensuring effective awareness, implementation and use of relevant Policies and SOPs |  |  |
| Describe your key challenges in relation to this and any action being taken |  |  |
| **Management of Risk (those that relate to clinical and care service delivery)** |  |  |
| Within your service how do you know that your governance arrangements are robust / known about? |  |  |
| Do you have robust procedures to ensure that all staff have current professional registrations where appropriate and are able to fulfil the requirements to maintain these? |  |  |
| How do you ensure that all your risks are identified, recorded and reviewed? (i.e. – what controls do you have within your service to manage risk? |  |  |

|  |  |  |
| --- | --- | --- |
| **D – USING DATA FOR IMPROVEMENT** | | |
| **Involving others** |  | **RAG** |
| Within the following groups how do you ensure appropriate involvement, engagement and use of feedback? Please give examples. |  |  |
| Patients / service users |  |  |
| Family |  |  |
| Carers |  |  |
| Public |  |  |
| Identify your approach for involving staff in service development and change |  |  |
| Are you using information from staff surveys – (e.g. – iMatter) and, if so, in what way. |  |  |
| Are you using Outcome Data (numbers and trends) for improvement (Complaints, Incidents, etc)? Please give examples. |  |  |

|  |  |  |
| --- | --- | --- |
| **E – LEADERSHIP** | | |
|  |  | **RAG** |
| **Vision and Strategic Direction** |  |  |
| Are staff demonstrating the organisations purpose, values and aims through their daily practice? Describe. |  |  |
| **Motivating and Inspiring** |  |  |
| Do staff feel motivated, empowered and supported to contribute to quality improvement and developments? How do you know? Describe. |  |  |
| **Developing People** |  |  |
| How effective are your processes for staff development, training, learning (i.e. – CPD, supervision, reflection, succession planning). Explain. |  |  |
| **Leadership of improvement and change** |  |  |
| Enabling staff to participate and introduce new ideas, take risks, innovate or develop higher level skills. Give an example of how you do this. |  |  |
| **Challenges** |  |  |
| Are there other areas of challenge within your service? How are they being managed / minimised? What are they? Explain. |  |  |

**Completed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Appendix 4b – GUIDANCE DOCUMENT**

**GUIDANCE FOR COMPLETING YOUR SERVICE GOVERNANCE PROFILE**

The following guide should help you to complete your profile and enable you to reflect on your service position in real time.

You should review this profile at least twice a year and involve key service delivery staff in its compilation and regular review.

This is self evaluation in action and will help you consider your service position and reflect your current performance and areas for improvement (see Section 6 and 7 of the East Lothian Health & Social Care Partnership Clinical Governance Framework). Completion of this profile will allow you to gather evidence that will demonstrate and support your position statement. In addition, it will prepare your service for any future scrutiny by internal means or external agency.

***RAG Rating***

Using a **R**ed, **A**mber and **G**reen rating process allows an at a glance approach to seeing where specific areas/issues require immediate attention and or consideration.

***Red***= Should be used where there is evidence that a situation and or known outcomes are such that patients, staff or the service are unsafe / at risk. This is where something requires urgent attention inclusive of perhaps additional support / resource.

***Amber*** = Is where a weakness has been identified either in the current service delivery or evidence / trends suggest a down turn in performance activity or significant risk to service users or staff is likely in the future. This situation is known to staff and they are actively taking action or preparing and putting in place a plan to mitigate the risk.

***Green*** = Where the service is delivering as planned and there are no concerns or issues to be addressed.

**OUTLINE OF SERVICE *and SECTION A -* KEY ORGANISATIONAL / SERVICE OUTCOMES**

This section is looking at your resources and any professional or statutory obligations that you as a service are expected to fulfil.

You should reflect on your current service position and identify where there are areas of good practice that you might wish to share or areas of concern that require improvement. What evidence can you use to substantiate / demonstrate your position statements / improvements? What steps are you taking to share these areas of good practice and learning?

*Recruitment, retention and staff deployment*

Think about the service you are required to deliver, the numbers and skills of staff required to do so. Consider the efficiency of your staff management processes and flag where you believe improvements are required. Consider the service you need to deliver and the profile and numbers of staff required to do so. This is where you may want to detail future proofing of your staffing resource. If you have a skill mix plan that needs to change over time the detail should be here. If you have a staffing problem looming consider your plan for addressing this e.g. - new approaches to delivering the service – up skilling staff etc.

If you use bank, locum or agency staff? Consider if this meets your needs and if your resources are effective enough to be flexible and reactive.

*Cost efficiencies*

Consider your service allocation of funding - in year budget – is it enough? Do you have any in year efficiencies to make? What is your plan for achieving this? How will this impact on the service? What evidence might you use to support your case?

*Learning from adverse events*

In this section you should consider the processes you have in place that allow the service to record and monitor untoward incidents, near misses and areas of concern. You should reflect on how information for learning is shared and how you evaluate if change / improvement has happened. If you have had any significant incident you should document the shared learning and improvement. If systems are not in place or are not robust then you should detail in here the steps you are taking to make things more effective / safe.

*Collaborating with Others*

This section is all about how you are working with others towards improvements. This can be in relation to direct service delivery, cost efficiencies or dealing with untoward trends etc. This is about working with others, not in isolation.

**SECTION B - QUALITY OF CARE / SERVICE DELIVERY**

*Meeting people’s needs / involving people*

Within this section you should consider how you evidence and demonstrate that you take the individuals needs and wants into consideration when planning their care and treatment. For example, giving choice where appropriate and demonstrate that what you are doing has good outcomes and that service users / carers and families are happy with the service / care they are getting.

*Service user information*

You should reflect in this section whether or not your service / specialty has appropriate and up to date information. This information could be about the service in general, treatments, support services available and any other related functions / support. Also consider if this information is as ‘Easy read’ as it should be and if these are in-house documents they should have a review date.

*Using feedback*

You should consider if the service has any process in place to gather the views of service users and others. This may relate to quality of service, care delivery, access or other things in general about the service being provided.

Do you have a system in place to regularly look at feedback that may come from other sources e.g. complaints, incidents, external publicity and can you evidence any change that you have made or plans that are being put in place for improvements as a result of feedback.

*Inspection and scrutiny*

You should detail internal and external scrutiny that applies to your service. The findings from such reviews should be shared with all staff across the service. If you have had a recent review is there a current action plan based on recommendations / requirements? You should consider the progress being made and where support may be required. You should also consider and detail the evidence that will support your position statements.

There is a raft of national and local standards. If there are key standards that are explicit to your service you should highlight these and consider how your service implements, applies and monitors achievement of them.

**SECTION C - POLICIES, PLANNING AND GOVERNANCE FOR CARE DELIVERY**

Policy and Standard Operating Procedures (SOP’s)

It is important that each service area has a process of assurance. Please describe how you can evidence and assure that your staff are aware of these and apply them to their day to day working practice. If you have gaps please consider in this section the action that you are taking to minimise individual and organisational risk.

**SECTION D – DATA FOR IMPROVEMENT**

*Involving others*

Within this section you may wish to expand on those things that you have detailed in earlier sections e.g. using feedback and Collaborating with others.

Specifically you should evidence how you involve staff and ensure that they are conversant with and have had the opportunity to be involved with service improvements / service new directions etc.

**SECTION E – LEADERSHIP**

*Vision and strategic direction*

Within this section you are asked to consider how the organisational values and directions are embedded in your service.

If you have initiatives that have allowed staff to develop and take risk then you should detail this here.

If you have local strategies for staff training and development, new service ideas etc then you should highlight within this section outlining any plans for improvement / staff engagement etc.

How do you ensure visibility of the leaders within your service?

***Challenges***

Use this section if there are things that are proving a challenge to the service / staff groups that have not been easily identified in any of the above sections.

**Appendix 4c: QUALITY OF CARE APPROACH - DOMAINS**



September 2018

**Appendix 4d – CARE INSPECTORATE QUALITY INDICATORS**

**The Quality Indicator Framework**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Key Question 1: How well do we support people’s wellbeing?** | **Key question 2: How good is our leadership?** | **Key question 3: How good is our staff team?** | **Key question 4: How good is our setting?** | **Key question 5: How well is our care and support planned?** |
| **1.1** People experience compassion, dignity and respect | **2.1** Vision and values positively inform practice | **3.1** Staff have been recruited well | **4.1** People experience high quality facilities | **5.1** Assessment and care planning reflects peoples’ needs and wishes |
| **1.2** People get the most out of life | **2.2** Quality assurance and improvement is led well | **3.2** Staff have the right knowledge, competence and development to care for people well | **4.2** The setting promotes and enables people’s independence | **5.2** Families and carers are involved |
| **1.3** People’s health benefits from their care support | **2.3** Leaders collaborate to support people | **3.3** Staffing level and mix meet people’s needs, with staff working well together | **4.3** People can be connected and involved in the wider community |  |
| **1.4** People are getting the right service for them | **2.4** Staff are led well |  |  |  |
| **Key question 6: What is the overall capacity for improvement?** | | | | |

**Appendix 4e: ASSURANCE PROCESS PYRAMID**

**MONTHLY – Feedback to GSM**

* Monthly Assurance Report
* Monthly meetings with 1st Line Managers

**REPORTS**

* Regular Exception Reports to CCGC

**WEEKLY – Informal Review**

* Risks
* Complaints
* Staffing
* Audit / Review update
* Incidents and Concerns
* Escalate as required

**DAILY – Informal Review / Huddles**

* Risk Assessment
* Compliance with controls / Policy / Action Plans / Legislation
* Report / Escalate if required
* Activity
* Escalate as required

**ANNUAL / BI-ANNUAL / QUARTERLY**

Formal Reporting and Controls to all parties (ELC, NHSL and IJB)

* Directions
* Accountability
* Assurance
* Resources

**RISKS / CONCERNS / INCIDENTS / WHISTLE-BLOWING**

**MONTHLY – Feedback to GSM**

Completion of Service Highlight Template

**CRITICAL INCIDENT REPORTING / WHISTLE-BLOWING**

**HEALTH & SOCIAL CARE PROVISION**

HAZARDS – RISKS – PROBLEMS – COMPLAINTS – THREATS – IMPROVEMENTS – ISSUES –

PERFORMANCE – COMPLIMENTS – USER EXPERIENCE – CONCERNS - ASSURANCE

**Appendix 4f: MONTHLY ASSURANCE REPORT**

**1ST LINE MANAGER / SERVICE MANAGER – Monthly Assurance Report**

|  |  |
| --- | --- |
| **DATE** |  |
| **Team / Service** |  |
|  |  |
| **1st Line Manager** |  |
| **Service Manager** |  |

**When completing this report you should highlight those areas of operational concern, challenge and success, this month and going forward taking account of your Service Governance Profile. There may be a requirement to reflect on agreed actions from the previous month. All sections may not require edit but you should consider each and annotate if no action required or Status Quo.**

**RAG Legend**

***Red***= There is evidence that a situation and or known outcomes are such that patients, staff or the service are unsafe / at risk. This is where something requires urgent attention inclusive of perhaps additional support / resource.

***Amber*** = A weakness has been identified either in the current service delivery or evidence / trends suggest a down turn in performance activity or that a significant risk to service users or staff is likely in the future. Staff **are** actively taking action or preparing and putting in place a plan to mitigate the risk.

***Green*** = Is where the service is delivering as planned and there are no concerns or issues to be addressed.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DELIVERY OF SERVICE - PERFORMANCE (effective)** | | | | | |
|  | | **Current Status** | **Required / On Going Actions** | | **RAG** |
| Progress against service plan / directions – What plans have you got? What are you aiming to do? How are you doing against these? | |  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
| **RESOURCE MANAGEMENT (safe, effective)** | | | | | |
|  | | **Current Status** | **Required / On Going Actions** | | **RAG** |
| Budget – (e.g. - financial position, impact on service) | |  |  | |  |
| Staffing (e.g. – vacancies, turnover, sickness absence, hotspots etc) | |  |  | |  |
| Recruitment – vacancy number, trend, difficulty | |  |  | |  |
| **ASSURANCE (safe, effective, person-centred)** | | | | | |
|  | **Current Status** | | **Required / Ongoing Actions** | | **RAG** |
| Professional regulation and statutory requirements - Monthly confirmation / highlight concern |  | |  | |  |
| Significant Adverse Events / Case Reviews / Large Scale Inquiries – cases commenced this month, trend compared to previous |  | |  | |  |
|  | |  | |  |
| Complaints - Trends / Cases |  | |  | |  |
|  | |  | |  |
| Progress against Action Plans – Audit, Inspections, Care Regulation |  | | |  |  |
|  | | |  |  |
|  | | |  |  |
| Public Protection – Trends / Cases |  | |  | |  |
| **QUALITY (Assurance / improvement / effective / person-centred )** | | | | | |
|  | **Current Status** | | **Required / Ongoing Actions** | | **RAG** |
| Quality Improvement Initiatives – e.g. – documentation, medication, Care Planning |  | |  | |  |
| Meeting Standards and other |  | |  | |  |
| PQI, Local Audit |  | |  | |  |
| Involvement |  | |  | |  |
| **LEADERSHIP (including Staff Support)** | | | | | |
|  | **Current Status** | | **Required / Ongoing Actions** | | **RAG** |
| PDP Progress |  | |  | |  |
| Development and Supervision |  | |  | |  |
| New training Initiatives |  | |  | |  |
| Fulfilment of obligatory Training |  | |  | |  |
| Staff Support |  | |  | |  |
| Achievements and Celebration |  | |  | |  |
| Publicity / Leadership Events |  | |  | |  |
| **INVOLVEMENT AND COLLABORATION** | | | | | |
|  | **Current Status** | | **Required / Ongoing Actions** | | **RAG** |
| Feedback: User, Family, Carer, Public, Staff |  | |  | |  |
| Involvement - User, Staff and Public |  | |  | |  |
| Engagement events |  | |  | |  |
| **RISKS / HAZARDS** | | | | | |
|  | **Current Status** | | **Required / Ongoing Actions** | | **RAG** |
| Health & Safety reports due this quarter – progress toward |  | |  | |  |
| Risk Register update |  | |  | |  |
| **SUMMARY of priorities / actions for coming month – Red and Amber issues** | | | | | |
|  | **Current Status** | | **Required / Ongoing Actions** | | **RAG** |
|  |  | |  | |  |
|  |  | |  | |  |
|  |  | |  | |  |

**Appendix 4g: GROUP SERVICE MANAGERS MONTHLY SUMMARY REPORT**

|  |  |  |  |
| --- | --- | --- | --- |
| **SUBJECT AREA** | **SERVICE AREA** | **ITEM OF SIGNIFICANCE / NOTE** | **RAG** |
| **DELIVERY OF SERVICE - PERFORMANCE** |  |  |  |
|  |  |  |
|  |  |  |
| **RESOURCE MANAGEMENT** |  |  |  |
|  |  |  |
|  |  |  |
| **ASSURANCE** |  |  |  |
|  |  |  |
|  |  |  |
| **QUALITY** |  |  |  |
|  |  |  |
|  |  |  |
| **LEADERSHIP** |  |  |  |
|  |  |  |
|  |  |  |
| **INVOLEMENT AND COLLABORATION** |  |  |  |
|  |  |  |
|  |  |  |
| **RISKS AND HAZARDS** |  |  |  |
|  |  |  |
|  |  |  |
| **IN-MONTH PRIORITIES** |  |  |  |
|  |  |  |
|  |  |  |

**Appendix 4h COMMITTEE (CCGC) REPORTING SCHEDULE – refer to Calendar (Appendix 4i) for month due** (P - Paper report, V - Verbal report, D – Discussion)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **No** | **Domain Item** | **Report Content** | **Frequency** | **PRESENTER** | **TIME** |
| **1** | **Apologies** |  | **Monthly** | **CHAIR** |  |
| 1.1 | Note of Previous Meeting |  | Monthly | CHAIR |  |
| 1.2 | Action Points |  | Monthly | CHAIR |  |
| **2** | **Group Service Summary - Monthly ReportsP** | | | | |
|  |  | Exceptions | Monthly | Group Service Managers |  |
| **3** | **Service Presentations** | | | | |
| 3.1 | Service 1 & Service 2 | PPT |  | Service Manager |  |
| **4** | **Policies & Procedures, Consultation & Submission responsesD** | | | |  |
| 4.1 | New Policy / Change in Legislation, regulation, standards and any Consultation & Submission Responses | Communications / Impact | Monthly | All |  |
| **5** | **East Lothian Trendsp** | | | | |
|  | Complaints | Update / Exceptions | Triannual | Discussion |  |
|  | Publicity, Public Engagement | Update / Exceptions | Triannual | Communications Representative |  |
|  | Public Protection | Update/ Exceptions | 6 monthly – on the same month | Chair of sub group |  |
|  | Health and Safety | Update / Exceptions | Chair of sub group |  |
|  | SAE / LSI / Serious Case Review | Update / lessons | Triannual | Discussion |  |
|  | Inspections | External Scrutiny | Triannual | Discussion |  |
|  |  | Local Audit | Triannual | Discussion |  |
|  |  | Action Plan Progress | Triannual | Discussion |  |
| 6.0 | **Quality** | | | | |
|  | Related Governance groups |  |  |  |  |
|  | * Resilience |  |  |  |  |
|  | * Data |  |  |  |  |
|  | * Workforce |  |  |  |  |
|  | * Pharmacy |  | 6 monthly |  |  |
|  | * GP Clusters |  | 6 monthly |  |  |
|  | * Quality Improvement Teams |  | 6 monthly |  |  |
| **7** | **Reports to : (Drafting, Planning & Preparation, Approval)** | | | | |
| 7.1 | IJB / partnership | Executive Reports | Annual | All |  |
| 7.2 | NHS Lothian | Annual | All |  |
| 7.3 | East Lothian Council | Annual | All |  |
| **8** | **AOCB** | Submissions |  | Chair |  |
| **9** | **DONM** | As meeting schedule |  | Chair |  |

**Appendix 4i – East Lothian Clinical and Care Governance Committee (CCGC) – Reporting Calendar**



**Appendix 4j: Group / Service Presentation Template – Handout format**



**Appendix 5** Acronyms and Glossary - East Lothian Clinical and Care Governance Framework

|  |  |  |
| --- | --- | --- |
| **Acronym / Word** | **Title** | **Definition** |
| A |  |  |
|  |  |  |
| B |  |  |
|  |  |  |
| C |  |  |
| CCGC (see also ELCCGC) | Clinical and Care Governance Committee | The committee itself - This is s a sub group of the integration Joint Board and holds devolved responsibility for all matters relating to assurance of safe and effectiveness delivery of clinical and  social care services. |
| CPD | Continual Professional Development | A process of continued learning and training to keep professional skills up to date and attain new skills. |
| D |  |  |
| DATIX |  | Web-based software to enable organisations to monitor and manage risks, incidents, Standard compliance etc. Used mainly in the NHS. |
| Duty of Candour |  | A legal framework effective from the 1st April 2018.  The overall purpose of the new duty is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm, as defined in the Act. It is the duty imposed on a public authority 'not to seek to win litigation at all costs but to assist in reaching the correct result and thereby improve standards'.  [dutyofcandour@gov.scot](mailto:dutyofcandour@gov.scot) |
| E |  |  |
| ELCCGC (also see CCGC) | East Lothian Clinical and Care Governance Committee | The committee itself - This is s a sub group of the integration Joint Board and holds developed responsibility for all matters relating to assurance of safe and effectiveness delivery of clinical and  social care services. |
| Escalation |  | A recognised process whereby staff at all levels of the organisation can bring concerns / risks to the attention of senior staff in a timely and appropriate manner. |
| eFinancials |  | Software system used by the NHS for financial data |
| F |  |  |
|  |  |  |
| G |  |  |
| GSM | Group Service Manager | Manager of a group of service |
| H |  |  |
| HGIYC | How Good Is Your Council | ?? |
| HIS | Healthcare Improvement Scotland | **Healthcare Improvement Scotland** (**HIS**) is the national **healthcare improvement** organisation for **Scotland**. It is a public body which is part of the **Scottish** National Health Service, created in April 2011. |
| HEAT | Health Improvement, Efficiency and governance, Access to service, Treatment appropriate to individuals | Government performance targets for the NHS. Replaced in 2016 by the LDP (Local Delivery Plan) targets. |
| I |  |  |
| IJB | Integration Joint Board | The Board responsible for Health and Social Care |
| J |  |  |
|  |  |  |
| K |  |  |
| KPI | Key Performance Indicators | A quantifiable measure used to evaluate the success of an organisation, employee, etc. in meeting objectives for performance. |
| L |  |  |
| LDP | Local Delivery Plan | Performance targets set for the NHS by the Scottish Government and agreed at a local level. Most of these were the previous HEAT targets. Commenced 2016. |
| LSI | Large Scale Inquiry | A term used in relation to an adult protection investigation. This is required where an adult who is a resident of a care home, supported accommodation, a NHS hospital ward or other facility, or receives services in their own home has been referred as at risk of harm and where investigation indicates that the risk of harm could be due to another resident, a member of staff or some failing or deficit in the management regime, or environment of the establishment or service. See Adult Support and Protection Code of Practice – May 2014 |
| M |  |  |
| Model of Care |  | A ‘Model of Care’ broadly defines the way health services are delivered. It outlines best practice for care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. |
| N |  |  |
|  |  |  |
| O |  |  |
|  |  |  |
| P |  |  |
| PC | Person Centred | A term for healthcare and social services which reflect the individual’s unique preferences, values and needs, identified and agreed upon in partnership with the health or social care provider. |
| PDP | Personal Development Plan | **Personal development planning** is the process of creating an action **plan** based on awareness, values, reflection, goal-setting and planning for personal development within the context of a career, education, relationship or for self-improvement. |
| PQI | Patient Quality Indicators | Patient care and service environment effectiveness audit measures, ensuring that service areas are delivering to agreed standards. |
| Q |  |  |
| Quality of Care |  | 'Quality' is a term used with different meaning within the NHS and covers many aspects of service provision, including waiting times for treatment, convenience and accessibility, cleanliness of facilities, and patient involvement, as well as the quality and effectiveness of clinical care.  This is the overarching terminology being used by Health care improvement Scotland (HIS) and encompasses the key domains of service delivery that will be considered under a joint approach to scrutiny and improvement. |
| Quality Clusters |  | **Is a grouping of GPs and other health and social care professionals led by GP practices to plan, provide and improve services locally.** Clusters are determined by individual NHS Health Board localities. |
| R |  |  |
| Resource Management |  | The collective term for managing all resources inclusive of staffing |
| RIVO |  | Web-based software to enable organisations to monitor and manage risks, incidents, Standard compliance etc. Used mainly by Councils. |
| Resilience |  | The organisations ability to continue to function in times of internal and external pressure including major incidents. |
| S |  |  |
| SAE | Significant Adverse Event | An incident/event that has led to death or significant harm to a member of staff, a service user and or significant damage to property resulting in risk or an inability to provide service. |
| SELFIE | Self Evaluation Framework Improvement to Excellence | A framework for self evaluation associated with the EFQM model |
| Statutory Duties |  | Legal obligations of public bodies and their office-holders – e.g. – Duty of Candour. |
| T |  |  |
|  |  |  |
| U |  |  |
|  |  |  |
| V |  |  |
|  |  |  |
| W |  |  |
|  |  |  |
| XYZ |  |  |
|  |  |  |