

**CLINICAL GOVERNANCE**

**SHREWSBURY COURT INDEPENDENT  
HOSPITAL**

**ANNUAL REPORT/AUDIT 2007-2008**

## Introduction

The Government's strategy for quality '*A First Class Service*' (Dept. of Health 1998) sets out a national agenda for the continuous improvement of patient care and services over the coming years. It indicates that these improvements will be achieved by setting national standards, ensuring local accountability for the implementation of clinical improvements (clinical governance), and national monitoring of standards.

Clinical governance focuses on all activities that support the development and continual improvement of patient care and services. Although the concept originally had a focus on NHS health care providers it is now deemed to equally apply to the private sector. It has been defined as a framework through which health care organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Clinical governance is underpinned by a duty on health care providers to put in place arrangements for monitoring and improving the quality of the health care that they provide.

A formal Clinical Governance programme commenced at Shrewsbury Court Hospital a number of years ago, and Clinical Governance Strategies have been developed and enhanced over recent years.

The committee has the following membership:

- General Manager
- Director of Operations
- Registered Manager
- RMO's x 2
- Staff Grade Psychiatrist – from August 2008
- Psychologist
- Clinical Lead Nurse
- Social Worker
- OT

Minutes are kept of the Clinical Governance meetings. These are circulated to the members of the committee and the Directors. The formal process for making copies available to staff is that reports put on the staff notice board and there is opportunity for full discussion at monthly staff meetings.

The Clinical Governance process at Shrewsbury Court has been audited under the following aspects/headings; Leadership & Management, Clinical Audit, Patient and Carer Involvement, Risk Management, Clinical Effectiveness, Workforce Issues, & Policies.

## **Leadership and management**

There is a commitment from senior levels in the organisation to Clinical Governance. This is evident from the regular input of the MDT into monthly Committee meetings and respective sub group membership.

During early 2008, a new Registered Manager came to post at Shrewsbury Court, and at the time of writing this audit of Clinical Governance, the hospital is currently recruiting a new Occupational Therapist to post.

The Board of Directors have also taken the decision to employ a Staff Grade Psychiatrist, in order to further increase patient contact, and enhance clinical standards across the Hospital. This is new territory for the Hospital, however discussions have already taken place with the successful applicant, about the anticipated clinical audit workload and the major part that it will play in the creation of this new post.

Overall responsibility for clinical governance lies with, the Registered Manager and the Clinical Team. Both are aware that quality improvement and clinical governance is one of their key operational responsibilities. There is an open and safe environment throughout the organisation in which good practice can be developed and maintained and where poor practice can be challenged. This is evidenced by the way in which staff, at all levels, have embraced the ongoing clinical audit programme.

All staff are made aware of the objectives of Clinical Governance during their initial induction programme. They are also informed about the arrangements and processes for clinical governance within the Unit. It is important that all staff feel that they have ownership of clinical governance. In order to achieve that it is essential that staff are kept fully informed about plans and any progress made.

The work of the Clinical Governance Committee and Audit Sub Groups, supports and ensures clinical governance arrangements, identifies work needed, and monitors/reviews progress. Audit reports are provided on a regular basis to the clinical governance committee and minutes of that committee are freely available.

## **Clinical Audit**

During 2007 there was a comprehensive Clinical Audit Strategy Programme for the Hospital covering a twelve month period. Audits were completed and presented to the staff team, however the Senior Management acknowledges that on occasions, attendance at such presentations could be poor. This is partly attributable to a busy hospital. This fact is addressed in the recommendations for 2008-2009 at the conclusion of this report.

Audits are generally multidisciplinary and are organised by the respective audit sub- groups. Audit at the present time takes place at Senior Level. Focus on the 2008 strategy will see a move towards involving more staff at all levels. This move has been welcomed by the Clinical Governance Committee, as consensus of opinion agrees that audit work needs to be done to involve nursing staff at all levels as well as other disciplines in the audit process in order to promote ownership and accountability.

The audit programme for April 2008- March 2009 needs to broaden its remit into other areas of the hospital. During 2007-2008 the predominant focus was in direct relation to medication, untoward incidents and clinical records etc. The 2008-2009 programme will illustrate marked improvements in the number of audits to be undertaken across a broader spectrum.

It is noticeable throughout the audits that have been carried out that though recommendations are always made for each audit presentation, it is not always clear where the responsibility lies for carrying out such

recommendations. The introduction of the new clinical audit tracker form or action plan, will now complete the paper trial for all audits conducted at the Hospital.

## **Patient & Carer Involvement**

The annual patient satisfaction survey was conducted towards the end of 2007, and showed an overall improvement at all levels.

Each year the survey is distributed by our Social Worker with the assistance of the Advocate to ensure independence and impartiality.

Morning patient community meetings take place on a daily basis, and are conducted by the Nursing Team. This provides full opportunity for patients to discuss the previous days events and to plan their day ahead.

Also in 2007, a new advocacy service was identified for Lavender Place. "Definitely Advocacy" is an advocacy and training service delivered by a Deaf Advocate. She has also provided training for staff on the role of advocacy, and issues within the Deaf Culture. This service has been well received by patients and staff alike.

Lavender Place, has extended its existing professional links with the National Deaf Service at Balham. Mr Herbert Klein, National Deaf Advisor, attends Lavender Place on a monthly basis to offer and provide support to staff, and meet with the Senior Management Team in order to plan and deliver improvements to the service and our patients. Senior Clinicians from Shrewsbury Court will be attending the National Deaf Service Conference in November 2008. In the meantime our RMO to Lavender Place will also spend time at the National Deaf Service and train alongside their staff. Mr Klein will also be involved in Clinical Governance and Audit at Shrewsbury Court. This represents a major step forward for our service, and will serve to improve the quality of care that we deliver and promote the interests of the patients within the service.

## **Risk Assessment**

During 2007-2008, Risk across the hospital was audited by various sub groups, dependent upon the area of risk. Certainly for the 2008-2009 strategy, it is essential that Risk has a sub group devoted to it in its own right to prevent ongoing fragmentation within such an important area of the Hospital's practices.

This aside, 2007-2008 saw comprehensive risk audits completed, in relation to Critical Incident Analysis, Infection control, (where notably and commendably percentage outcomes increased in all areas from 65-92% in 2006-2007, to 92-95% in 2007-2008) Health and Safety with environmental audits, and individual patient risk assessments to name but a few.

Towards March 2008, individual risk management for patients has been overhauled by the Clinical Team and Registered Manager, and the Clinical Governance Committee will look forward to assessing how these improvements develop over the forthcoming months.

## **Clinical Effectiveness**

During 2007-2008 this sub group has concentrated its efforts towards Medication Audits, and reviewing medical procedures policies. It is envisaged that the addition of the Staff Grade to this sub group during mid 2008 will extend this groups remit and audit activity levels to cover, Allergies, and Physical Health.

This year has also seen this group promote the new post of Activity Co-ordinators, and in line with this review the activity programme for patients which has been enhanced across the hospital.

### **Workforce Sub Group**

This sub group will be fully developed during 2008-2009. To date, Personnel Audits have been completed, as well as regular input from the Training Department to provide statistical information and training feedback from staff and their development.

In accordance with the 2008-2009, the role of this sub group will be extended to cover Staff Survey (planned to late 2008), supervision and appraisal audits (during 2007 covered as an all encompassing Personnel Audit), sickness and absence audit, enhanced training audits, and the development of an internal CPD programme that all staff will be free to access.

CPD is an important and valuable contribution to the Hospital for all staff, and it is intended that in its infancy it will be facilitated by the Senior Clinical Team, with all staff invited to attend. Over time, any member of staff will be able to volunteer to run a CPD session, and also Guest Speakers will be invited to attend and facilitate such sessions.

All staff are encouraged to engage in evidence based practice through the ongoing staff training programme and also through clinical governance activity. Staff are encouraged to undertake further education and training, where appropriate, through the NVQ programme and professional development courses. Appropriate records of staff participation/attendance in training are maintained. Patients are not directly involved in staff training.

All staff are to be congratulated in the valuable contributions made towards the successful re-accreditation of Shrewsbury Court to the Investors in People programme during February 2008.

### **Policies**

During Autumn 2007, the Board of Directors created a new post and recruited a Director of Operations. This new post, along with a change a Registered Manager in February 2008 heralded a new change of direction and focus at the Hospital. The Clinical Strategy of Clinical Governance is to be overhauled, in order to streamline sub groups and allow them to maintain their focus, and for members to concentrate on their specialities.

Furthermore, during 2007-2008, there was a Policy sub group within Clinical Governance responsible for the ratification of all policies hospital-wide. This is to change within the 2008-2009 strategy and this group will be dissolved, with policies disseminated to appropriate sub groups when review and ratification is deemed necessary.

The Clinical Governance Committee acknowledges that with a change of direction in policy and practice at the hospital as a result of new management, such reviewing of all policies will be undoubtedly labour intensive, and may encroach in part onto the clinical audit activity of the respective sub groups. However reviews of policy and practice are equally as important as audits in improving standards to compliance and practice at Shrewsbury Court.

## **Recommendations for 2008-2009**

Shrewsbury Court Independent Hospital as an organisation is accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. The Clinical Governance Committee is central to that process.

1. Clinical Audit Strategy 2008-2009 is revised and re-issued. This will reflect changes to the membership of the Clinical Team, and the realignment of sub group structure, terms of reference and composition.
2. Staff at all levels to become involved in audit to promote ownership and accountability.
3. Development is still required to ensure a consistent process for providing feedback to staff in relation to clinical audits, and to ensure that action plans, with deadlines are adhered to for all recommendations made following audit.
4. Committee to review patient participation and input into Clinical Governance.
5. Expansion of the Clinical Audit Programme across the Hospital.
6. Policies to be disseminated to appropriate sub groups for review and ratification.
7. With the introduction and development of CPD across the Hospital in the later half of 2008, consider the possibility of facilitating audit presentations.

**Sheridan Bailey**  
**Director of Operations**  
**March 2008**