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Dear Colleague

GOVERNANCE IN THE HPSS –
Clinical and Social Care Governance: Guidelines for Implementation

Summary

1. This guidance is intended to enable you to formally begin the process of developing and implementing clinical and social care governance arrangements within your organisation or area of responsibility with effect from the date of receipt of this circular. It should be read in conjunction with guidance already issued on the implementation of a common system of risk management across the HPSS and the development of controls assurance standards for financial and organisational aspects of governance.

Background

2. The consultation document "Best Practice – Best Care" set out proposals for a framework to improve the quality of services delivered by the Health and Personal Social Services (HPSS). Decisions on the way forward with implementing these proposals were announced in July 2002 focusing on three main areas:

(i) Arrangements for setting clear standards for services;

(ii) Mechanisms for promoting local delivery of high quality health and social care services through clinical and social care governance arrangements, reinforced with a statutory duty of quality. These arrangements will be supported by programmes of continuous professional development and lifelong learning and strengthened by enhanced arrangements for professional regulation; and

(iii) Effective systems for regulating services and monitoring the delivery of services.

3. In July 2002 the Department wrote to Chief Executives of HSS Boards, Trusts, Special Agencies and Chairs of Local Health and Social Care Groups setting out these new arrangements in more detail and enclosing a draft circular on clinical and social care governance for comment. The attached circular has been revised to take account, as far as is possible, of comments received from the HPSS.

4. The requirements set out in this circular have been kept to a minimum for this stage. The detailed requirements arising from clinical and social care governance will be developed in conjunction with the HPSS starting with a series of workshops across Board areas in January/February 2003. Further guidance will be issued as necessary.

Action Needed

5 While it is recognised that there has been some progress in developing clinical and social care governance arrangements, what has been lacking is a consistent approach throughout the region. This guidance builds on the work of the past and maps out the way ahead, providing a management framework for clinical and social care governance. The following is the minimum list of actions, covered in greater detail in the circular, which need to be taken by each organisation.

- The appointment of a senior professional at board level to provide leadership in relation to clinical and social care governance arrangements and processes.

- The designation of a committee to be responsible for the clinical and social care governance of the organisation. This may be an entirely new committee or the function could be taken on by an existing committee e.g. the Risk Management Committee.

- An evaluation of the current clinical and social care governance arrangements in the organisation to establish the baseline from which developments must begin.

- The formulation of a plan for the development and maintenance of clinical and social care governance arrangements.

- A system to deliver routine progress reports to the board and a formal progress report within the organisation's Annual Report.

6. The structure of this circular is as follows:

- Introduction
- Key Policy Objectives
- The Challenge
- Tailoring Guidance to Individual Organisations
- Monitoring Performance
- Next Steps
- Resources
- Further Guidance

For ease of reference the following paragraphs summarise what is covered by each section.

INTRODUCTION (Paragraphs 1-3) **Page 5**

This section explains the purpose of the circular, acknowledges what some HPSS organisations are already doing and points to the need for all to follow this guidance.

KEY POLICY OBJECTIVES (Paragraphs 4-19) **Pages 5-8**

This section identifies the key elements of the strategy for improving quality in the HPSS and sets clinical and social care governance in the context of the wider quality agenda. It covers the statutory duty of quality, defines clinical and social care governance and deals with the culture change that will flow from these new arrangements.

THE CHALLENGE (Paragraphs 20-38) **Pages 8-13**

This section sets out the challenge to HPSS organisations to ensure that implementation of clinical and social care governance is successful. It identifies the key steps which all HPSS organisations will need to take in the first year and focuses on establishing accountability and leadership arrangements; assessing the organisation's baseline position; agreeing a development plan and implementing that plan.

TAILORING GUIDANCE TO INDIVIDUAL ORGANISATION'S NEEDS (Paragraphs 39-48) **Pages 13-15**

This section provides guidance on how organisations may tailor the guidance to meet their particular organisational needs while adhering to the underlying principles of clinical and social care governance and the statutory duty of quality.

MONITORING PERFORMANCE (Paragraphs 49-54) **Pages 15-16**

This section refers to arrangements for monitoring clinical and social care governance and sets out the core functions of the new Health and Social Services Regulation and Improvement Authority.

NEXT STEPS (Paragraph 55) **Pages 16-17**

This section lists the actions (with effective dates) that must be taken by the Department and HPSS organisations.

INTRODUCTION

1. The purpose of this circular is to provide guidance specific to clinical and social care governance. The Department recognises that many HPSS organisations have already begun to develop their own systems for clinical and social care governance based on guidance issued in England Scotland and Wales. While there are many parallels in approach, our arrangements for clinical and social care governance must take account of the organisational structures and manner of delivery of services currently in place here. This guidance must be read in the context of guidance already issued on the implementation of a common system of risk management across the HPSS and the development of controls assurance standards for financial and organisational aspects of governance.

2. It is important, therefore, that while much good work has already been done in relation to the development of clinical and social care governance, from now on all organisations must apply the principles set out in this guidance.

3. It is not intended to be prescriptive on an exact model to be used. It is for your organisation or group, together with your co-workers, staff, users and local communities to determine how best to implement arrangements which take account of the services delivered by you and your organisation at every level. This circular `does, however, set a framework for action which highlights the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure delivery of high quality health and social care.

KEY POLICY OBJECTIVES

4 The key elements of the strategy for improving quality in the HPSS are:

(i) Arrangements for setting clear standards for services;

(ii) Mechanisms for promoting local delivery of high quality health and social care services through clinical and social care governance arrangements, reinforced with a statutory duty of quality. These arrangements will be supported by programmes of continuous professional development and lifelong learning and strengthened by enhanced arrangements for professional regulation; and

(iii) Effective systems for regulating services and monitoring the delivery of services.

Statutory Duty of Quality

5. Clinical and social care governance arrangements within organisations which provide or commission services will be underpinned by a statutory duty of quality. The introduction of this duty will mean that accountability for the quality of services provided, including commissioning, is comparable with the statutory duty that exists on HPSS bodies in relation to the financial management of their organisations.

6. The statutory duty of quality will apply to Health and Social Services Boards (HSS Boards), Health and Social Services Trusts (HSS Trusts), and some Special Agencies

(the Regional Medical Physics Agency, the Northern Ireland Blood Transfusion Agency and the NI Guardian ad Litem Agency) for the services they commission and provide to the public. While the statutory duty of quality will not, for now, directly apply to the management boards of Local Health and Social Care Groups (LHSCGs), the Central Services Agency (CSA) and the remaining Special Agencies, they too must put in place effective clinical and social care governance arrangements which will also be subject to monitoring.

7. Everyone employed in the organisation, individuals, teams and corporate board members, have a role to play in ensuring effective clinical and social care governance arrangements work throughout their organisation and must be aware of their role and responsibilities.

What is clinical and social care governance?

8. "Best Practice – Best Care" defines clinical and social care governance as a framework within which HPSS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment. Clinical and social care governance is about organisations taking corporate responsibility for performance and providing the highest possible standard of clinical and social care.

9. The clinical and social care governance framework is intended to build on and strengthen existing activity relating to the delivery of high quality care and treatment. This includes activity on:

- audit;
- identifying, promoting and sharing good practice, learning lessons from best practice as well as poor performance.
- risk assessment and risk management;
- adverse incident management;
- quality standards;
- complaints management;
- clinical and social care effectiveness;
- evidence-based practice;
- research and education;
- effective leadership and management;
- a clear policy aimed at improving communication between management, users, staff and local communities;
- policies aimed at securing effective user involvement, and which enable local communities to engage in all aspects of clinical and social care governance;
- effective recruitment and selection procedures;
- continuing professional and personal development; and
- professional regulation.

10. The framework is designed to bring all of these components together to secure a co-ordinated approach to the provision of high quality care and treatment, while ensuring a greater focus on the standard of clinical and social care practice. This will ensure that high quality, effective treatment and care is delivered and that where things do go

wrong, they are quickly addressed and lessons are learnt to help prevent re-occurrence.

11. Clinical and social care governance is central to achieving improvements in the quality of services provided in the HPSS. Its successful development and delivery is crucial to the overall success of the framework for quality improvement.

12. The integration of health and social services means that governance arrangements must include social care in addition to clinical care, where operationally appropriate, within HSS Boards, LHSCGs, HSS Trusts, the CSA and Special Agencies. In addition, local arrangements for clinical and social care governance must complement the existing roles and management and executive professional responsibilities in place within HSS Boards and HSS Trusts.

Changing Culture

13. The introduction of clinical and social care governance arrangements will bring about a fundamental change in the culture of HPSS organisations. Clinical and social care governance is about developing a culture that safeguards high standards, promotes and supports improvements in practice and in the treatment and care delivered. This culture needs to be one of openness, transparency, listening to the views of users, staff and local communities, learning, sharing information and developing partnerships.

14. A culture that encourages open discussion and reflection on practice allows staff to learn from their experiences. This includes both celebrating what is done well and learning from what is done less well. If an organisation is to encourage staff to report incidents and learn from mistakes, it must develop an open and honest culture, rather than one of blame and shame and a reliance solely on disciplinary procedures. Developing the right culture is perhaps one of the biggest challenges in establishing clinical and social care governance processes. It will take dynamic leadership, time and commitment from all levels of the organisation.

Effective User and Community Involvement

15. Effective user and community involvement is crucial to the delivery of high quality treatment and care. Clinical and social care governance arrangements must involve users in ways that are meaningful, appropriate and acceptable to them. Each organisation needs to have a clear policy about and strategy for securing user and local community involvement. Involving users will provide a means whereby organisations can show that they are accountable to the population they serve. It can also help to improve staff/user communication and understanding as well as make use of the specific expertise that users have to offer. Similarly, HPSS organisations need to have regard to the relationship they have with their local communities and to consider how best these communities can be empowered to participate in the arrangements for clinical and social care governance.

16. "Token involvement syndrome" must be avoided. Users and local communities can and should play a much more meaningful role in the planning and delivery of services. They could for example identify issues that may inform the way in which information is gathered or through a partnership approach with professionals, they

could help determine the scope, focus and outcome of a service initiative. Organisations will wish to take account of the work and expertise developed by Health and Social Services Councils

17. Ultimately the effective involvement of users and local communities within clinical and social care governance arrangements will be determined by the approach taken by individual organisations

Development of Clinical and Social Care Governance

18. While those HPSS organisations which have already begun developing arrangements are to be commended for the work they have already done, clinical and social care governance is a dynamic and continuous process and full implementation will be an evolving process. There are however some practical steps that all HPSS organisations should address.

19. These involve setting up local structures to ensure clinical and social care governance arrangements are in place. Whilst the range of local structures will be dependent on the size and complexity of each organisation, there are some core arrangements which should always be put in place. These are establishing and maintaining:

- clear lines of responsibility and accountability for the overall quality of treatment and care;
- effective systems to identify, value, promote and share good practice within the organisation and where appropriate outwith the organisation particularly in circumstances where services are commissioned from an external provider;
- a comprehensive programme of quality improvement activities, including arrangements for ensuring users and local communities will be fully involved in securing high quality services;
- clear policies aimed at assessing and managing risk; and
- an open, honest and proactive system where people can report poor performance, near-misses and adverse events to allow them to be appropriately dealt with, lessons learnt and shared within and where appropriate outwith the organisation.

THE CHALLENGE

20. Clinical and social care governance has significant implications for the way in which HPSS organisations will conduct their business. Issues relating to the quality of clinical and social care provision will feature highly on their agenda and will form an equal and complementary strand with financial and organisational governance issues in their accountability.

21. The leadership provided within HPSS organisations will be the key to creating a culture and environment where the delivery of the best possible standards of care and treatment is seen to be the responsibility of everyone in the organisation.

Where are we now and what do we need to do?

22. Whilst it is recognised that HPSS organisations may already have made varying degrees of progress in developing governance arrangements, there are key steps which all HPSS organisations will need to take in the first year. These are:

Step 1: establishing leadership, accountability and working arrangements;

Step 2: depending on how advanced clinical and social care governance arrangements are within an organisation either:

(a) review their current arrangements and progress towards complying with the principles set out in this guidance;

or

(b) carry out an initial baseline assessment of capacity and capability;

Step 3: formulate a development plan, in the light of this review or assessment securing agreement and support for this plan across the organisation; and

Step 4: clarify reporting arrangements for clinical and social care governance as part of the management of the organisation and arrange for the preparation of an annual report on what has been achieved and what is planned for subsequent years.

Taking these steps is the key requirement arising from this circular. The following paragraphs set out guidance in relation to each of the four steps.

Step 1: Establish leadership, accountability and working arrangements

23. The Chief Executive of each organisation will be accountable to his/her board for the delivery of quality, treatment and care by the organisation in the same way as he/she is already responsible for financial and organisational matters.

24. The following paragraphs set out the suggested leadership arrangements within HPSS organisations that commission or provide services directly to the public. It is important to remember, however, that whatever leadership arrangements are decided upon it is essential that all organisations demonstrate:

- **inclusivity:** ensuring that all staff in the organisation are involved and kept fully informed about the purpose and progress of the clinical and social care governance programme;
- **commitment from the top:** reporting and having access to the Chief Executive and the board, particularly when problems need to be resolved or barriers to progress have been identified;

- **good external relationships:** forging strong open working partnerships with users, local communities, health and social care organisations and other agencies in the locality;
- **good internal relationships:** forging ownership of clinical and social care governance by the employees of an organisation;
- **continuing focus:** keeping the arrangements on course and not being deflected from the goals that the organisation has set itself;
- **accounting for progress:** being able, on request, to provide a comprehensive overview of progress with the clinical and social care governance arrangements programme throughout the organisation; and
- **communication:** with all staff in the organisation and with external partners, users and local communities on a regular basis.

Leadership arrangements within all organisations

25. The Chief Executive of each organisation (or in the case of LHSCGs the management board) will designate a senior professional at board level to support him or her in the discharge of his or her role as accountable officer for the delivery of quality care and treatment within the organisation. The leadership arrangements will differ according to local circumstances but it is likely that the senior professional will wish to assemble a multi-disciplinary team, with each member having responsibility for different aspects of the arrangements. It may well be that such a multi-disciplinary team has already been established as part of the organisation's overall approach to risk management.

26. It is proposed that this senior professional will provide leadership in relation to clinical and social care governance arrangements and processes. He/she will support and encourage good practice, while ensuring that where problems are identified, appropriate remedial action is taken.

27. The senior professional will also develop local systems for engaging the views of users and staff and mechanisms that will support the dissemination of clinical and social care standards, best practice and innovation. In addition the senior professional will be expected to put in place mechanisms for ensuring the production of clinical and social care governance reports. The senior professional will look to other key professional and staff groups to provide support. They will need to meet as often as necessary to promote and maintain a culture of quality and will be monitored on behalf of the organisation by the committee with responsibility for clinical and social care governance.

Leadership arrangements – Committee of the board with responsibility for clinical and social care governance

28. HPSS organisations to which the statutory duty of quality applies, must designate a Committee to be responsible for the oversight of the clinical and social care governance of the organisation. This may be an entirely new committee or the function could be taken on by an existing committee e.g. the Risk Management Committee.

29. The Committee with responsibility for clinical and social care governance should represent an appropriate balance of skills and interests and organisations should give consideration to how they can best ensure user and local community input into discussions about the development and maintenance of clinical and social care governance at the various levels of the organisation.

30. The Committee will be responsible for assuring the organisation's board that effective and regularly reviewed structures are in place to support the implementation and development of clinical and social care governance. The Committee must ensure:

- that where problems are identified, appropriate remedial action is taken;
- local community and user input into the development and maintenance of clinical and social care governance arrangements;
- effective mechanisms for engaging the views of users and staff are developed; and
- the provision of a report, to the board, which includes recommendations and any remedial action taken or proposed if there is an internal failing in systems or services.

31. The Committee should appoint a chair. In most organisations this should be a NonExecutive Director. The organisation's Chief Executive and other Executive Directors may be invited to attend meetings. The Committee should meet as often as required to discharge its role effectively and efficiently but not less than three times a year.

Step 2(a): Review current arrangements or progress towards complying with the principles set out in this guidance

32. For those organisations, which have begun to develop their own systems for clinical and social care governance, a review of current clinical and social care governance arrangements should be undertaken in light of this guidance. The review should include a report on the progress made towards complying with the components and features set out in paragraph 9 above as well as an assessment of the extent to which the criteria in Step 1 have been applied in relation to leadership and management.

or

Step 2(b): Carry out a baseline assessment of capacity and capability

33. For those organisations, which have not begun to develop a system of clinical and social care governance, implementation should start with a baseline assessment of the organisation's position. The baseline assessment should include:

- an analysis of the organisation's strengths and weaknesses in relation to current performance on quality;
- identification of any particularly problematic services;
- assessment of the extent to which data is in place for quality surveillance;
- establishing whether there are deficiencies in existing key mechanisms;
- ensuring integration of quality activities and systems;
- making clear the links with health and wellbeing investment programmes, delivery plans and local priorities; and
- designing ways in which underpinning strategies such as information management and technology, human resources, continuing professional development and research and development will support clinical and social care governance.

34. The review/baseline assessment (whichever is appropriate) should let the whole organisation see what it is good at, what it is less good at, and the areas needing to be developed. It should provide the basis for a development plan that includes clear milestones. When a quality initiative has significant resource consequences, discussions should take place within the context of the health and wellbeing investment plans, taking account of planned service development frameworks (when in place) and the available resources. Decisions will have to be made about which improvements are feasible and at what pace.

Step 3: Formulate a development plan and secure agreement across the organisation in the light of this review/assessment

35. On the basis of the review/baseline assessment, organisations can then establish a plan for developing and maintaining clinical and social care governance arrangements. This should address issues such as reducing any gaps in current performance, developing infrastructure (ie reporting structures, information management and technology, human resources etc), identifying and responding to staff development and organisational developmental needs and resource implications. The aim should be to build on existing best practice.

Step 4: Clarifying reporting arrangements

36. Organisations will be expected to include an up-date on progress in the development of clinical and social care governance arrangements in their Annual Reports for 2002-2003. Thereafter they will be expected to devote a specific section in subsequent

Annual Reports, giving a full account of their activities related to clinical and social care governance, what has been achieved and what is planned for subsequent years. In addition, organisations should ensure that they have appropriate mechanisms in place to deliver routine reports to the board on progress made in implementation, building on current best practice arrangements.

37. Clinical and social care governance reports for all organisations should attempt to answer three broad sets of questions about implementation

- ***Where did we start?*** – the review/baseline position;

- ***What progress have we made?*** - the development plan for the year and the monitoring and evaluation undertaken; and

- ***Where are we going?*** – the development plan for the coming year.

38. It is important to remember that each organisation will have to develop systems in accordance with its structure and responsibilities.

TAILORING GUIDANCE TO SUIT INDIVIDUAL ORGANISATION'S NEEDS

Health and Social Services Boards (HSS Boards)

39. HSS Boards will be expected to adopt the principles of clinical and social care governance in relation to all services they provide or commission. The principles will guide the planning of services and the development of Health and Wellbeing Investment Plans.

40. HSS Boards will be responsible for developing a culture that encourages high quality treatment and care. They will also be responsible for ensuring a high quality public health function and that the local health and social care infrastructure encourages open, confident, and responsive quality treatment and care provision.

41. As outlined at paragraph 23, the Chief Executive of each HSS Board will be responsible and accountable to his/her organisation's board for ensuring the HSS Board's responsibilities with regard to clinical and social care governance are discharged. The Chief Executive will be expected to look to his/her Professional Directors to provide support.

42. In addition to the steps outlined at paragraph 22, the HSS Boards should:

- identify the priorities for quality improvement in the HSS Board area through mechanisms such as needs assessment processes and as identified in local and regional action plans and other sources of information;
- base decisions on investment and action on the basis of these priorities;
- recognise and promote good practice within their own organisation and those organisations from which they commission services;

- ensure good clinical and social care governance of the HSS Board's own internal processes and functions such as public health, communicable disease control, and clinical and social care advice on commissioning;
- support, facilitate and ensure the development of clinical and social care governance amongst all local HPSS organisations, including LHSCGs.

Health and Social Services Trusts (HSS Trusts)

43. HSS Trusts will be expected to adopt the principles of clinical and social care governance in relation to all services they provide directly or commissioned by the Trust. The principles will guide the provision of services and the development of Trust Delivery Plans. Chief Executives in line with the statutory duty of quality must make sure that their organisations have in place effective clinical and social care governance arrangements.

44. In addition to the steps outlined in paragraph 22, HSS Trusts should:

- recognise and promote good practice within their own organisation and those organisations from which they commission services;
- reflect the pursuit of quality in Trust Delivery Plans; and
- have regard to/support the clinical and social care governance arrangements within other organisations locally.

Central Services Agency and the Special Agencies

45. Central Services Agency and the four Special Agencies, the Regional Medical Physics Agency, the Northern Ireland Blood Transfusion Agency, the Health Promotion Agency and the Guardian ad Litem Agency will be expected to adopt the principles of this guidance in relation to the services they provide and commission. In addition the Chief Executives of the Regional Medical Physics Agency, the Northern Ireland Blood Transfusion Agency and the Guardian ad Litem Agency will be responsible and accountable to their respective boards for the quality of care (as they will have a statutory duty of quality for the services provided directly to the public) provided by that agency in the same way as they are already responsible for financial matters. It will be for each Agency's board to develop the framework appropriate to discharge their relevant responsibilities, in line with general principles set out in this guidance.

Local Health and Social Care Groups (LHSCGs)

46. The establishment of LHSCGs provides an organisational platform around which a system of clinical and social care governance can be developed. The principles of clinical and social care governance apply to all LHSCGs including independent contractors. (Further guidance will be issued on this). Therefore the steps outlined in paragraph 22 and subsequent paragraphs apply equally to LHSCGs. The leadership structure may differ according to the size and complexity of the LHSCG. The following paragraphs are intended to give an example of a structure for clinical and social care governance within LHSCGs.

47. Each LHSCG should appoint a professional at management board level (a clinical and social care governance lead) to co-ordinate clinical and social care governance activities. This professional, who will need to be supported by a local sub-group or task group will:

- review current arrangements, carry out a baseline assessment and formulate a development plan;
- ensure that clinical and social care governance activity takes place across the whole of the LHSCG in a planned way;
- provide leadership in relation to clinical and social care governance arrangements within the LHSCG;
- co-ordinate the efforts of the LHSCG in the pursuit of the provision of high quality services;
- support and encourage good practice, while ensuring that where problems are identified appropriate remedial action is taken;
- develop mechanisms for engaging the views of users, local communities and staff;
- identify a development programme to meet the individual and organisational needs of all staff who work within the LHSCG, and work collaboratively with other organisations to meet these needs;
- have regard to the clinical and social care governance arrangements within other organisations; and
- ensure that there is an agreed mechanism in place for reporting progress on clinical and social care governance.

48. The clinical and social care governance lead will account to the management board of the LHSCG, which in turn will account to the HSS Board for the implementation of clinical and social care governance activities at LHSCG level.

MONITORING PERFORMANCE

Monitoring of Clinical and Social Care Governance Arrangements

49. Monitoring of clinical and social care governance will take several forms. The Department through its accountability arrangements will monitor implementation in HSS Boards, HSS Trusts, the Central Service Agency and Special Agencies. HSS Boards will provide the first line of external monitoring for its development within LHSCGs.

50. In addition, the new Health and Social Services Regulation and Improvement Authority (HSSRIA) will provide the independent monitoring of clinical and social care governance. The HSSRIA will have the following core functions:

- regulate services;
- inspect services;
- provide advice;
- conduct reviews of clinical and social care governance arrangements;
- carry out systematic service reviews; and
- undertake investigations.

51. It is intended that the powers of HSSRIA will be wide ranging. In addition to the regulatory function, it will take the lead in conducting reviews of clinical and social care governance arrangements. It will, through a rolling programme of local reviews of HPSS organisations, independently scrutinise the arrangements developed to support, promote and deliver high quality services. It will also help organisations identify and tackle serious or persistent shortcomings in clinical or social care service delivery. The ultimate aim of HSSRIA will be to support HPSS organisations in the delivery of high quality, safe services for the user.

52. As well as the HSSRIA, the Department, subject to the Minister's approval, can call on the Commission for Health Improvement (CHI) to undertake specific service reviews and in exceptional cases, where it is considered that expertise in clinical issues from elsewhere is required, to assist in other investigations.

53. Over time the HSSRIA will have a key role in providing users, the public and the Minister with the assurance that systems are in place to ensure that the best possible standards are being adhered to and the risk of something going wrong is greatly reduced.

54. HSSRIA will have to work collaboratively with other organisations involved in review or inspection such as the Northern Ireland Audit Office, the Health and Safety Inspectorate, the Social Services Inspectorate and the Pharmacy Inspectorate.

NEXT STEPS

Action by all HPSS organisations

55. The following actions must be taken by all organisations:

From the date of receipt of this circular

- formally begin the process of developing and implementing arrangements for effective clinical and social care governance;

By 28 February 2003

- identify the senior professional at board level to provide leadership in relation to clinical and social care governance;

By 31 March 2003

- designate a Committee with responsibility for clinical and social care governance (or in the case of LHSCGs, a sub-group or team), and appropriate supporting structures; and
- complete a review/baseline assessment or arrangements within the organisation that identifies current systems that support clinical and social care governance and identifies systems that require further development;

By 1 May 2003

- formulate and agree the organisation's plan for developing and maintaining effective clinical and social care governance arrangements;

By 1 June 2003

- incorporate a requirement to comply with the principles of clinical and social care governance into service agreements with provider organisations to take effect from 1 April 2004;

By 30 November 2003

- provide update on progress in the development of clinical and social care governance arrangements in Annual Report for 2002/03.

RESOURCES

56. The Department wishes to engage with HPSS organisations on the development of clinical and social care governance and to that end a series of workshops has been arranged for January and February 2003, across the four HSS Board areas, to discuss the way forward including the establishment of a Clinical and Social Care Governance Support Team (CSCGST). It is envisaged that the CSCGST will be multi-disciplinary and will consist of staff experienced in management, clinical and social care practice and family health services. It could provide support and training for HPSS organisations and develop further implementation guidance. In November 2002 an additional £0.25m (rising to £0.4m from 1 April 2003) was allocated to the HPSS to support governance and in recognition of the additional costs of implementing risk management arrangements, including clinical and social care governance arrangements.

FURTHER GUIDANCE

57. This circular will be supplemented by further guidance as necessary.

Yours sincerely

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Director