A guide to clinical governance reviews in NHS acute trusts / CHI.

A GUIDE TO

Clinical governance reviews in NHS acute trusts

The Commission for Health Improvement (CHI) is a non-departmental public body. It was established under the 1999 Health Act as part of the government's reforms to help improve patient care. It has statutory powers and is accountable to government for its work, but operates independently.

It has been apparent for some time that the standard of care offered by the NHS varies greatly. It can vary between hospitals, between departments in the same hospital and between general practices. There is not always an obvious reason for this variation. CHI's purpose is to assist the NHS in England and Wales to address unacceptable variations in patient care and to assure, monitor and improve the quality of clinical care.

CHI works at both local and national level to assure, monitor and improve the quality of clinical care. It collaborates closely with the NHS as well as with other bodies such as the Royal Colleges, professional organisations and regulatory and voluntary bodies. Its main functions are:

- to provide independent scrutiny of local clinical governance arrangements to support, promote and deliver high quality services. The Commission is carrying out a rolling programme of reviews of clinical governance arrangements in every NHS trust, primary care trust and health authority (the health authority programme includes staff such as GPs and dentists)
- to conduct or assist with investigations into serious service failures. CHI has the capacity for rapid investigation and intervention to help put things right
- to carry out studies that monitor and review the implementation of National Service Frameworks, National Institute of Clinical Excellence (NICE) guidance and other key NHS policy priorities
- to provide national leadership to develop and disseminate clinical governance principles and to identify and share good practice

CHI has adopted six key principles that underpin all its work:

- the patient's experience is at the heart of CHI's work
- CHI will be independent, rigorous and fair
- CHI's approach is developmental and will support the NHS in continuous improvement
- CHI's work is based on the best available evidence and focuses on improvement
- CHI will be open and accessible
- CHI will apply the same standards of continuous improvement to itself that it expects of others

A GUIDE TO

Clinical governance reviews in NHS acute trusts

CHI

COMMISSION FOR HEALTH IMPROVEMENT

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Preface

CHI has written this guide mainly for those involved in the clinical governance review process in NHS acute trusts, including managers, clinical and non-clinical staff. It will be of interest to government departments, other regulatory and audit agencies in the NHS, academics and NHS commentators, patient representative bodies and members of the public. It will be updated twice a year and is also available on CHI's website (Appendix A).

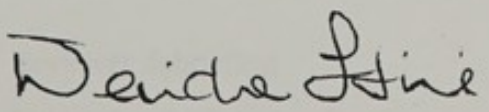
CHI is developing the review methodologies for other types of NHS organisation such as health authorities, primary care trusts and NHS trusts covering mental health services and ambulance services. It will publish guides to clinical governance reviews in those organisations as well.

This guide is part of CHI's commitment to being open and accessible in all its work. It describes what is involved in the clinical governance review process in acute trusts and explains CHI's methods. It sets out the review framework and process, the data and documents required and the rationale for each stage of the process.

Trusts will benefit most from reviews if they are well prepared in advance. We hope that this guide will be a useful contribution to that preparation and assist trusts in their progress in implementing clinical governance. In addition, it includes appendices that show in detail the issues CHI will be focusing on during a review.

The review approach was piloted in full at four trusts during 2000 (Appendix B). As a result, CHI has refined the review methods and aspects of the methodology will develop as CHI carries out more clinical governance reviews.

CHI would like to thank all those who helped to develop clinical governance reviews, including the trusts where the review methods were piloted. A key feature of the reviews is the involvement of NHS professionals as review team members, and we are grateful both to them and to their seconding organisations. Each team also includes a lay member, who can take the viewpoint of patients and the public, and we are fortunate to have their involvement. They all have the opportunity to encourage good practice throughout the NHS and thus be a force for change and continuous improvement in patient care.



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Contents

1 The clinical governance review framework

What is clinical governance?

The government's white paper, *A First Class Service*, defined clinical governance as

> *'a framework through which NHS 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.'*[1]

The purpose of clinical governance is to ensure that patients receive the highest quality of NHS care possible. It covers the organisation's systems and processes for monitoring and improving services, including:

- consultation and patient involvement
- clinical risk management
- clinical audit
- research and effectiveness
- staffing and staff management
- education, training and continuing personal and professional development
- use of information to support clinical governance and health care delivery

Effective clinical governance should therefore ensure:

- continuous improvement of patient services and care
- a patient-centred approach that includes treating patients courteously, involving them in decisions about their care and keeping them informed
- a commitment to quality, which ensures that health professionals are up to date in their practices and properly supervised where necessary
- a reduction of the risk from clinical errors and adverse events as well as a commitment to learn from mistakes and share that learning with others

Aims of clinical governance reviews

CHI's rolling programme of clinical governance reviews will cover every NHS acute trust in England and Wales. The reviews look at the effectiveness of trusts' clinical governance arrangements and have five principal aims:

1. *A First Class Service: Quality in the New NHS*, Department of Health, 1998.

- to provide the public and people using NHS services with objective and fair assessments of NHS trusts' progress towards introducing effective clinical governance
- to help the NHS achieve evident and continuous improvements in the quality of patient care
- to help the NHS reduce unacceptable variations in the quality of clinical services
- to identify and disseminate good practice in clinical governance
- to increase understanding of clinical governance and the factors that determine its effectiveness

Guiding principles

CHI's reviews of clinical governance incorporate the six key principles that guide all its work.

The patient's experience is the central focus. The inclusion of a lay member in every review team reinforces this focus. Reviews capture information about the direct experience of NHS patients across the services they use in an acute trust. They also look at how the trust perceives the experiences of the patients it treats. CHI is particularly interested in waiting times, how care is organised, whether patients are treated with privacy, dignity and respect, environmental issues such as cleanliness and clinical effectiveness and outcomes.

CHI has designed the review process to be **independent, rigorous and fair.** CHI and its review teams collect, analyse and assess evidence according to a consistent framework (see 'Assessing clinical governance' in this chapter). The health care professionals in the review team work within the NHS and understand the overall context of acute trusts but do not work in the region in which the trust under review is located. All review team members undergo a rigorous selection process and are chosen for their ability to take an objective and independent standpoint.

The review process is about **development and support for continuous improvement.** CHI helps trusts to plan and prepare for the review, using existing information wherever possible. This process helps the trust to look carefully at its own performance. CHI also shares good practice identified during reviews. The style of reviews is developmental, collaborative and non-confrontational.

CHI's work is **evidence-based and focused on achieving improvement.** Review findings are based on robust evidence collected throughout the review. Review reports do not contain specific recommendations for change. Instead they highlight areas for action to help the trust work out the most appropriate means of achieving change in its specific context. The trust then produces an action plan, in response to the report.

CHI is publishing this guide as part of its commitment to being **open and accessible** about every aspect of the review process and its development. In addition, all review reports are published in hard copy and on the Internet, once the trust has agreed their factual accuracy.

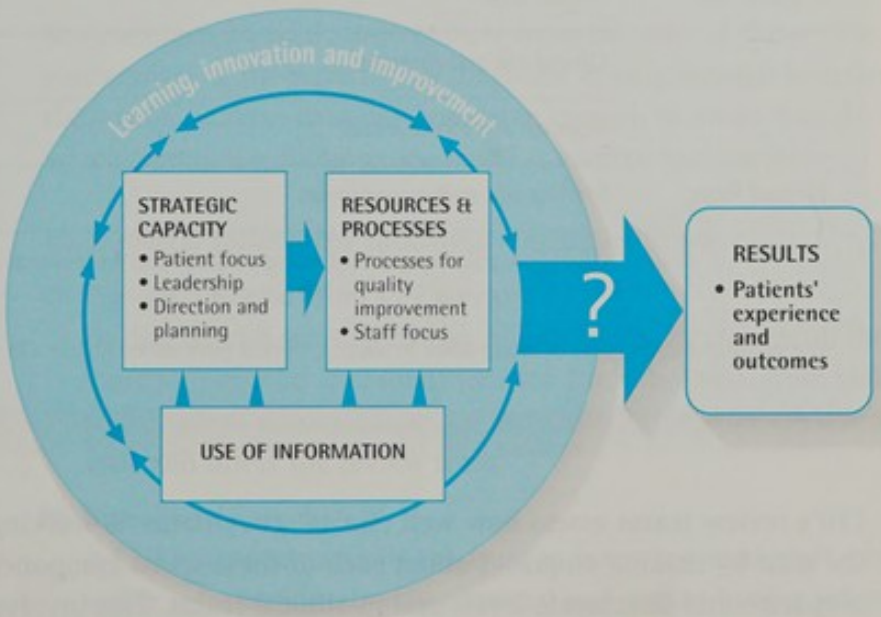
CHI applies the principle of **continuous improvement** to itself and its review methods. It recognises that there is much to learn from other review and inspection bodies and seeks to combine their best practice with its own. CHI has evaluated the pilot review phase to inform and refine the review approach. Formal evaluation will continue as the review programme develops, including seeking the views of organisations under review.

Assessing clinical governance

CHI is introducing a systematic framework for assessing clinical governance in trusts so that judgements made in reports of reviews are reliable, fair and consistent. The assessment framework is being developed with the NHS Clinical Governance Support Team in England and the Clinical Effectiveness Support Unit (CESU) in Wales (CESU closed at the end of March 2001). This will ensure that consistent messages are given to trusts about clinical governance. (See Appendix A for contact details).

CHI's model for clinical governance (Figure 1) illustrates its belief that effective clinical governance depends upon a culture of continuous learning, innovation and development and will improve patients' experience of care and treatment in hospital. Over time, CHI will use the information it accumulates from reviews to help determine which aspects of clinical governance are the most important for improving patients' experience and outcomes.

Figure 1: CHI's model for clinical governance



Work is in progress to identify the dimensions of the **patients' experience and outcomes** under the 'RESULTS' part of the model so that CHI can assess the information it collects about what it is like to be a patient and interpret information about clinical processes and care outcomes.

CHI evaluates **clinical governance** by exploring three key, interlinked areas identified in the model:

- **strategic capacity:** how far does the trust's leadership set a clear overall direction that focuses on patients? How well is it integrated throughout the trust?
- **resources and processes:** how robust are its processes for achieving quality improvement, such as consultation and patient involvement and clinical audit? How effective are the trust's arrangements for staff management and development?
- **use of information:** what information is available on patients' experience, outcomes, processes and resources, and how does the trust use it strategically and at the level of patient care?

Each of these areas comprises a number of components that CHI examines in every trust. CHI has so far identified seven components of 'RESOURCES AND PROCESSES' and 'USE OF INFORMATION' (Figure 2). Work is being carried out to identify the components of 'STRATEGIC CAPACITY'.

Figure 2:
Components of clinical governance – resources and processes and use of information

	Component
Resources and processes	
(i) processes for quality improvement	Consultation and patient involvement
	Clinical audit
	Clinical risk management
	Research and effectiveness
(ii) staff focus	Staffing and staff management
	Education, training and continuing personal and professional development
Use of information	Use of information to support clinical governance and health care delivery

CHI's review teams assess how well clinical governance is working throughout the trust by making enquiries about each of these seven components at corporate and directorate levels and in clinical teams. This involves collecting information systematically about **review issues** that have been defined for

each component (Appendix C). CHI will introduce similar methods to assess information collected about components of 'STRATEGIC CAPACITY' in future rounds of reviews.

On the basis of the evidence collected, CHI's reviewers assess each component of clinical governance against a four-point scale:

- I = little or no progress at strategic and planning levels or at operational level
- II = worthwhile progress and development at strategic and planning levels or at operational level, but not at both
- III = good strategic grasp and substantial implementation. Alignment of activity and development across the strategic and planning levels and operational level of the trust
- IV = excellence – co-ordinated activity and development across the organisation and with partner organisations in the local health economy that is demonstrably leading to improvement. Clarity about the next stage of clinical governance development

There is wide variation within trusts in progress made developing the component parts of clinical governance. At this stage of development, CHI believes it is most useful to trusts to assess each component separately to help them prioritise their development of clinical governance. It will not make judgements to produce an overall rating for a trust. Assessments at level I require urgent action, and at level II, action. When the assessment is level III or IV, trusts are already making good or excellent progress. CHI will encourage these trusts to continue to make improvements to achieve the next stage of clinical governance.

Review phases

Reviews take 24 weeks to complete from the start of the review to the final preparation of the report. This timescale is long enough to collect and rigorously analyse data, but intensive enough to mean that the evidence on which the review findings are based is current and useful.

Each review follows the following timetable:

- **Pre-visit preparation (15 weeks).**
  During this phase, CHI carries out an initial meeting with the trust (start-up meeting), collects and analyses data from the trust, from stakeholders and from patient diaries, identifies the areas for detailed review during the site visit and briefs the review team
- **Site visit (1 week).**
  A CHI review team visits the trust to interview trust staff, observe practice, verify information already obtained and gather further information

- **Production of report (8 weeks).**
  The review team agrees the key findings and the review manager presents them to the trust and writes a report on CHI's findings. The publication process normally takes a further two weeks, following which the report is publicly available in hard copy and on CHI's website

Each of these stages is described in more detail in Chapters 3, 4 and 5 – The Review Process.

Six to eight weeks after the site visit, CHI runs a workshop with the trust to help it consider the areas for action in CHI's report, identify its future priorities and translate them into achievable and measurable objectives. The trust then draws up an action plan, which is approved and monitored by either the regional office or the National Assembly for Wales.

2 The review programme

Selecting organisations for review

CHI's rolling programme of clinical governance reviews has started with acute trusts. CHI will also review all health authorities, local health groups (in Wales), primary care trusts and NHS trusts covering community services, mental health services and ambulance services in England and Wales on a similar basis. The approaches to reviewing those NHS organisations are under development and will be similar to those used by the acute programme.

CHI selects NHS trusts to review on a random basis from within the eight English regions and from Wales, using a sampling technique that ensures that the number of trusts selected is spread proportionately across each region. Reviews are not normally triggered by special concerns. However, CHI has the capacity to 'fast-track' clinical governance reviews of certain organisations and bring these forward in the programme. 'Fast-track' clinical governance reviews may be triggered by a request from an individual or organisation, a recommendation made as a result of a CHI investigation or where a request is made for an investigation but a review is more appropriate. All requests for 'fast-track' reviews and investigations are assessed against a set of guiding principles. If a decision is made to 'fast-track' a review, the trust is informed.

In addition, CHI meets regularly with each regional office and the National Assembly for Wales to look back at completed reviews and to discuss the future review programme. This enables CHI to identify organisations where the review should be delayed, for example because of an impending merger or change of management.

The review team

Teams carrying out clinical governance reviews are multidisciplinary. Each team normally comprises: a nurse, a doctor, an NHS manager, a lay member and another clinical professional who is not a doctor or a nurse, for example a pharmacist or physiotherapist. A CHI review manager co-ordinates the team's work and a team of analysts collates and analyses data about the trust. CHI informs the trust of the membership of the team in advance of the site visit.

The review manager is a member of CHI staff. He/she co-ordinates the review and acts as a link between CHI and the trust throughout the process. The review manager leads and supports the team during the site visit, ensures that all the relevant evidence is collected and analysed and writes the report.

The analysts are responsible for analysing data provided by the trust and other national data. They also support the review by undertaking ad hoc analyses as requested and by reviewing the trust's information systems before the site visit.

CHI recruits reviewers through national advertising. It requires high standards of its reviewers and operates a rigorous competency-based selection process. Potential reviewers attend a one-day assessment centre.

Once selected, all reviewers attend an intensive two and a half day training course simulating the clinical governance review process. It provides reviewers with a thorough grounding in CHI's review methods and helps develop the skills needed for reviewing, such as interviewing and listening, note taking and analysis. CHI requires all its reviewers to comply with its code of conduct. They also sign a confidentiality agreement that continues after they have finished working for CHI as a reviewer, as well as a declaration of interests.

Reviewers are on short-term secondments. They spend around 10 days on each review and normally carry out one or two reviews per year while remaining in their current job within the NHS. This means that they are up to date with current practice and understand the context within which trusts work. They can also help spread identified good practice within their own organisations. In addition, the lay reviewers bring the patient's and the public's perspective to the review.

CHI welcomes applications from those interested in becoming a reviewer. Please contact the human resources team at CHI or consult CHI's website, which contains details of vacancies.

3 The review process – pre-visit preparation

Pre-visit preparation is vital to the review and shapes the whole review process. During this phase, CHI collects quantitative and qualitative data – both from the trust and from national and other sources – using a variety of methods including stakeholder meetings and patient diaries. The framework for assessing clinical governance determines the data to be collected. CHI analyses the data to build up a picture of the trust and to identify areas to focus on during the site visit. These include areas of good practice and areas for further development.

CHI aims to minimise the work for the trust during this phase. It ensures that trusts have sufficient time for data collection and uses data that is already in the public domain where possible (a copy of the data request is available on the CHI website). Over time, CHI will reduce the data it requires by careful targeting so that the supply and analysis of data is more economical and effective.

Key to the review's success are visible commitment from trust senior management and communication to staff. CHI's communications team has prepared a handbook for trusts to help them with the internal and external communications aspects of the review. CHI also offers assistance to trusts in media handling and other communications issues when reports are published.

Contacting the trust

At least three months before the 24-week review process starts, CHI informs the trust of its selection as a clinical governance review site and of the timing of the review team's visit. CHI assigns a member of staff, the review manager, to co-ordinate the review and to act as a link between CHI and the trust throughout the process.

CHI also asks the trust to nominate a key contact – the trust co-ordinator – to collect information and arrange local meetings. This is a crucial role in

ensuring that the review runs smoothly (Figure 3), and review teams value the trust co-ordinator's assistance highly. The time commitment required for this role will vary from trust to trust, but on average it will involve around 30–40 days of the co-ordinator's time from start to finish. The trust co-ordinator should have an understanding of how the trust as a whole operates and be senior enough to have influence at trust board level. Appendix D describes the role of the trust co-ordinator in more detail.

Figure 3: Role of the trust co-ordinator

The trust co-ordinator:

- acts as a link between CHI and the trust
- communicates information throughout the trust about CHI and the review process
- works with the CHI review manager to make sure that the review process runs as smoothly as possible
- co-ordinates the return of trust data and documents
- administers patient diaries
- co-ordinates the return of comments on the pre-visit brief to CHI
- arranges the timetable for the review team's visit and schedules appointments
- is available throughout the site visit
- arranges a verbal feedback session for the review manager to present the key findings of the review
- co-ordinates the return of comments on the factual accuracy of the report to CHI
- arranges the objective setting workshop

CHI writes to the trust in week one of the 24-week clinical governance review process with background information and a request to start the data collection process and arrange a start-up meeting.

WEEK 1

Collecting data and documents

To inform the review, CHI collects and uses national data sets such as clinical indicators. It also asks the trust to provide:

- **documentation from internal sources.** This includes information on the trust's profile, strategies and business plans and information about the individual components of clinical governance, such as clinical audit and patient surveys
- **documentation from external sources.** This includes reports of other external organisations that visit the trust, for example, Royal Colleges, Postgraduate Deaneries, external auditors and Investors in People

- an extract of data from the trust's patient administration system (PAS) over the previous four years. This is data that the trust routinely generates for the Nation Wide Clearing Service

The request for data and documents is comprehensive in its coverage of clinical governance and there should not normally be a need for the trust to provide documentation in addition to that which CHI has requested. Looking at this data and these documents helps to focus the review visit and avoid duplicating work already carried out by the trust or other external reviewers.

CHI asks the trust to return the data and documents within three weeks of the start of the review, in electronic form if possible. CHI analysts spend a further four weeks analysing it to produce a pre-visit brief (see 'Pre-visit brief and selection of clinical teams' below) to inform the review visit. It is then passed to the review manager for internal quality assurance.

Start-up meeting

The review manager and a CHI communications officer meet with the trust to discuss the review. The meeting normally includes the chief executive, medical director, nursing director, director responsible for allied health professionals, communications manager, trust co-ordinator for the review and the clinical governance lead for the organisation. The aim is to explain the process, the trust co-ordinator's role, the preparation needed and the support that CHI's communications team will provide to the trust, as well as answer any queries. The trust also has the opportunity to give background to the organisation and highlight any issues about clinical governance they think are important.

CHI asks the trust to complete a questionnaire about its progress towards implementing clinical governance (available on request from CHI or see the CHI website). The questionnaire provides important background information to the review team and helps to inform the planning of the site visit. It also gives the trust an opportunity to highlight areas of good practice as well as highlighting areas for further development. The trust is requested to return this document to CHI two weeks from the start-up meeting.

The patient diary

A fundamental part of the review is to assess the patient experience at the trust. CHI assesses the trust's perspective – for example, its complaints systems and how it includes patients in research and audit. It also asks patients directly about their care in areas such as access to services, organisation of care and communication and information. Research has shown that this type of qualitative information provides a good illustration of the impact of health care on individuals and can have a powerful influence on clinical and organisational practice.

CHI therefore includes in the review a retrospective patient diary, completed by a random selection of 200 patients who have been in, or have attended, hospital in the previous two months. The trust co-ordinator plays a central role in administering the patient diaries. CHI has designed its methods carefully to preserve patient confidentiality and to ensure that patient volunteers have sufficient information to give informed consent. An example of one of the two patient diaries used is shown at Appendix E.

CHI is researching and developing a strategy for reaching patients who might have difficulty in making their views heard. This might be because they do not speak or read and write English or because they have a sensory or physical disability. The review process in the future will include methods for seeking these people's views.

Meetings with stakeholders

Achieving an understanding of the trust's local context and external perspectives on the trust's clinical governance arrangements, is a significant feature of the review. CHI therefore spends around two days meeting with local people and non-statutory organisations with an interest in the trust. They include members of the public, voluntary and not for profit organisations, staff associations and trade unions. Staff from the trust may also attend. CHI holds the meetings at a local venue with disabled access and conducts them privately. Information may also be received by letter, telephone or e-mail.

CHI spends a further day conducting formal meetings with the regional office or National Assembly for Wales, the health authority, the community health council, primary care groups/trusts or local health groups, the community trust, local authorities with social services responsibilities and the external auditors. In addition to providing context and helping to focus the review, these meetings help to raise local awareness of the review and action planning processes.

Pre-visit brief and selection of clinical teams

CHI analyses the internal and external documents and PAS data provided by the trust to produce a pre-visit brief. Its purpose is to provide background information to the review team and to help identify key issues and areas of good practice to follow up through the site visit. It provides initial findings on patient outcomes and experiences, strategic capacity, resources and processes and use of information (see 'Assessing clinical governance' in Chapter 1). CHI sends the brief to the trust, giving one week to comment on its factual accuracy and to identify any gaps.

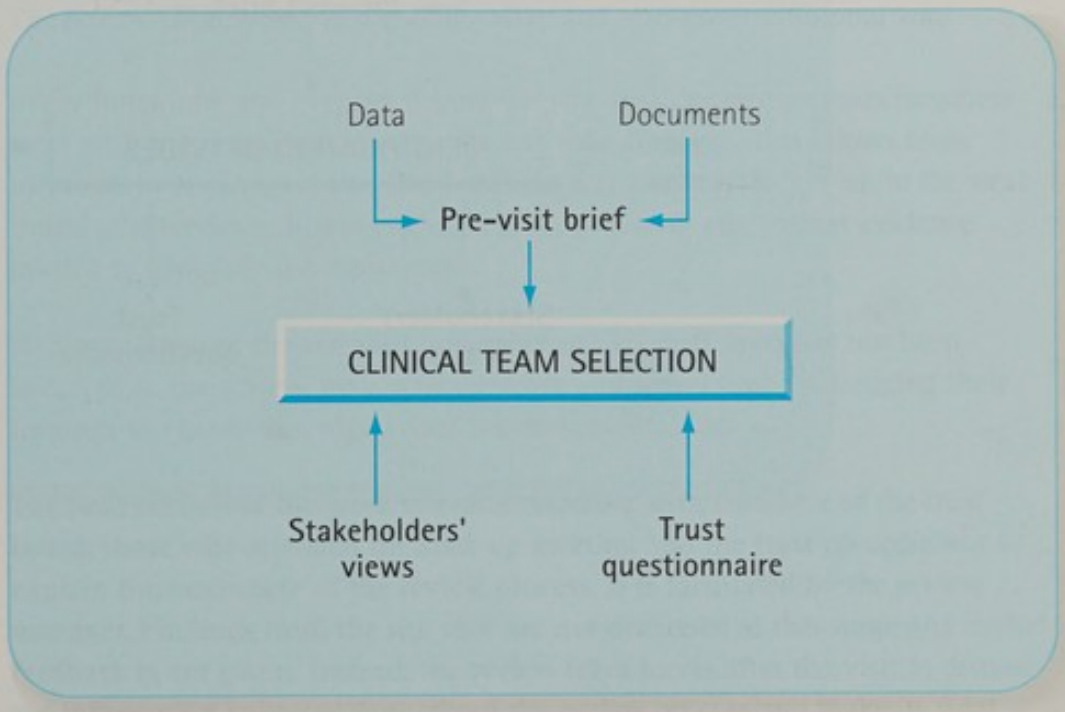
The pre-visit brief is a working document. It does not form part of the final report, but information within it informs the site visit and supports CHI's eventual findings. It collates information in a way that the trust can use to assess its own performance.

WEEK 11

CHI uses the pre-visit brief and information gathered from the trust questionnaire and from stakeholders to select three clinical teams in the trust for the CHI review team to look at in depth (Figure 4). The aim is to test whether clinical governance arrangements are working at 'grass roots' level, not to carry out service reviews. The teams chosen are therefore not intended to be representative across the whole trust but to provide evidence of clinical governance effectiveness. CHI also gives the trust the opportunity to nominate three to five teams which it thinks represent good practice worthy of sharing elsewhere. One of these is included in the clinical team selection.

A clinical team comprises the staff who care for a specified group of patients. It is based around the staff who work on a particular ward, outpatients' clinic, theatre suite, or other location in a hospital, but extends to other staff who care for the patient while in hospital. A clinical team caring for patients who have fractured a hip for example, might be based around the staff who work on an orthopaedic ward. Other staff who work in the accident and emergency department, theatres, rehabilitation, pharmacy, diagnostic units and the outpatients' department have an input in the care of these patients and may also be included in the clinical team. CHI informs the trust which clinical teams it has chosen and which staff are included in them so that the trust co-ordinator can start scheduling interview appointments with staff.

Figure 4: Selection of clinical teams within the trust



WEEK 14

Briefing the review team

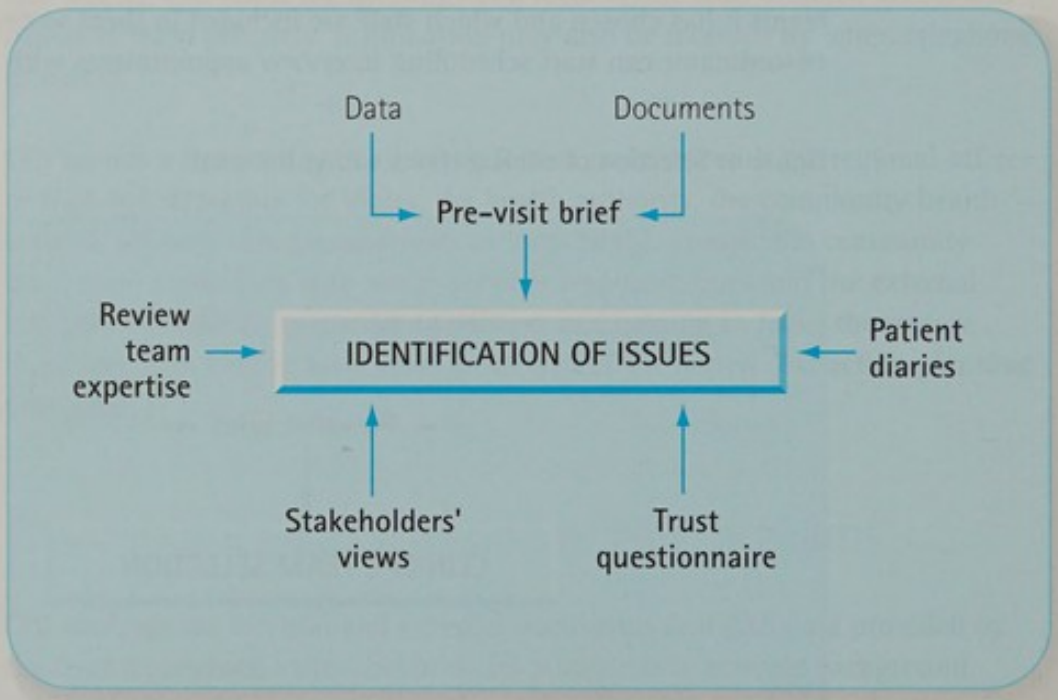
To help the review team understand both the trust's context and how it is approaching clinical governance, CHI sends each reviewer the pre-visit brief and other documentation and analysis and holds a briefing meeting no later than one week before the site visit. The review team and the review manager attend, as well as one of the analysts responsible for analysing the pre-visit data and documents.

The purpose of the briefing meeting is:

- to decide which issues to follow up with the clinical teams selected and with corporate members of staff
- to allocate responsibility for aspects of the visit to team members
- to highlight areas of good practice to explore in more detail
- to agree the timetable for the visit

The review team uses the pre-visit brief and information from the trust questionnaire, stakeholders and patient diaries to help it decide on the issues to follow up (Figure 5).

Figure 5: Identifying clinical governance issues to focus on during the visit



4 The review process – site visit

Review team visits trust for a week

The purpose of the site visit is to test out areas selected for review during the preparation phase, to validate information already collected and to gather further evidence about the trust's progress with clinical governance. Visiting the trust also allows the review team to assess the 'softer' issues, such as communication between and within clinical teams and relationships within the trust, for example between managers and clinicians.

The review team spends an intensive five and a half days on site, including at least one visit to the trust at night. An indicative timetable for a site visit is shown at Appendix F.

Reviewers interview trust staff, observe what happens in areas of the trust, such as wards and outpatients, and fill in any data or information gaps. The review team works in a collaborative and non-confrontational way.

Every lunchtime and evening during the site visit, the review team members meet with the review manager to discuss their findings. This allows team members to exchange notes and highlight any issues to follow up in the next round of interviews. It also enables them to identify any further evidence needed to complete the assessment.

Half way through the site visit a member of CHI staff, who has not been involved in the review, may visit the team and spend time challenging their findings to ensure that objectivity is being maintained.

The final session of the week is a short meeting with members of the trust board, those who attended the start-up meeting and the trust co-ordinator to explain the next stage of the review process. It is facilitated by the review manager. Findings from the site visit are not discussed at this stage and verbal feedback is not given. Instead, the review team meets after the visit to discuss the information collected throughout the review process and make its final judgements. These findings are then fed back to the trust no more than four weeks later.

The CHI review manager plays an important role in co-ordinating the review team's work during the visit. He or she may also participate in the interview sessions.

The review manager's main tasks are to:

- act as the formal link between CHI, the review team and the trust
- manage the process and make sure it runs as smoothly as possible
- provide leadership and support to the review team
- quality control the process and the reviewers' activities

The review manager facilitates review team discussions and runs debriefing and planning sessions with the review team throughout the week.

Interviewing trust staff

The review team interviews a cross-section of trust staff of all grades and professions, including non-clinical staff, in scheduled interviews lasting between half an hour and an hour. Most interviews are carried out by reviewers in pairs, allowing one person to ask questions while the other takes notes. Some interviews are group interviews, but the majority are with an individual member of staff.

The structured interviews cover the main components of clinical governance. For example, as part of assessing consultation and patient involvement, interviews with clinical team members seek to find out whether:

- staff are aware of patients' views of the service and whether action is taken as a result
- staff are committed to keeping patients and carers informed of progress
- patient privacy and dignity are respected
- patients are involved in the planning and delivery of their care
- care is organised around patients' needs
- lessons are learned from patient complaints and changes made as a result

At the end of each interview, the reviewer completes a site visit recording form.

Information provided by individual members of staff is non-attributable in CHI's final report. However, if a member of staff raises serious issues such as allegations of professional misconduct, CHI has a responsibility to act and it may not be possible to guarantee that person's anonymity. CHI provides training and consistent guidance to all reviewers on the procedure to follow in such situations.

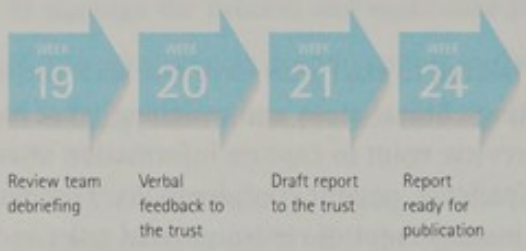
Observation

In addition to interviewing staff, the review team carries out scheduled observation sessions in a variety of areas, for example, wards, the accident and emergency department, waiting areas, the X-ray department and the cafeteria. The review team does not observe within consulting rooms, operating theatres or treatment areas.

These sessions involve talking to staff who have not been included formally on the visit timetable, visiting clinical areas and watching what happens in these areas. They enable the review team to capture information about privacy, dignity and respect for patients, patient confidentiality, communication between professionals, management of environmental risks and how facilities meet patients' needs.

The review team will only talk to patients after consultation with, and with the agreement of, the member of staff in charge. Reviewers will not talk to patients without the patient's verbal consent.

5 The review process – reporting



The next phase of the process is to produce a report for the trust that will also be made available to the public and people who use the trust's services. The purpose of the report is:

- to provide a picture of where clinical governance is working well and where the trust needs to take action
- to highlight areas of good practice
- to provide information for the trust to use in identifying its priorities for improvement

The report outlines areas for action rather than making specific recommendations. This enables the trust to consider the best way of achieving change in its specific context and circumstances.

Reviewer debriefing

The review team meets two to three weeks after the clinical governance review visit. Team members discuss and agree their key findings against CHI's clinical governance assessment framework. They consider the evidence gathered throughout the review process (from the pre-visit brief, trust questionnaire, stakeholders, patient diaries and interviews and observation during the visit). In reaching conclusions, the review team weighs carefully the robustness of the evidence. This ensures that judgements made in reports are supported by information from a number of different sources (Figure 6).

The team also plans the verbal feedback to be given to the trust by the review manager in advance of the written report.

Figure 6: Evaluating supporting evidence

Degree of confidence	*Amount of evidence and sources*	*Reporting back to the trust* ✓= include in written report or verbal feedback ✗ = does not appear in written report or verbal feedback ? = may appear in written report or verbal feedback
Very confident	A number of sources: data; documents; interviews; observation	✓ Report ✓ Verbal feedback
Confident	Several items of information from the same source type (e.g. interviews) from different areas or organisations One interview or observation confirmed by an independent source	✓ Report ✓ Verbal feedback
Some confidence	Several items of information from the same source type (e.g. interviews) from the same area or organisation	? Report ✓ Verbal feedback
Little confidence	One interview or observation only	✗ Report ? Verbal feedback

WEEK 20

Presenting findings to the trust

Shortly after the review team debriefing meeting, the review manager returns to the trust to present the key findings of the review. This allows the trust to discuss CHI's findings and to provide additional relevant information.

The review manager provides the trust with a short briefing note outlining the key findings. This enables action planning to begin in advance of the objective setting workshop (see Chapter 6: After the review).

WEEK 21

Writing and publishing the report

The review manager drafts a report containing CHI's key findings. The audiences for the report are the health and social community and its users, and it is made publicly available. It is therefore written in a clear, accessible and jargon-free style. The report contains five main sections, the detail of which will vary according to the review findings (a detailed outline structure is shown at Appendix G):

- **The trust's context:** relevant details about the trust's size, income and services and information about the population it serves
- **The patient's experience:** outcomes of patient care, the extent to which care is organised around the patient, the quality of care and patients' accounts of their experience
- **Use of information:** the availability and use of information about the care process, outcomes and patients' direct experience
- **Resources and processes:** the trust's arrangements for staff management and its processes for quality improvement, such as risk management, clinical audit and consultation and patient involvement
- **Strategic capacity:** the trust's overall strategic approach and processes for focusing on the patient

The review team comments on the draft report. CHI then sends the report to the trust approximately five weeks after the site visit. The trust has one week to comment on its factual accuracy. CHI also sends the report to the Department of Health and the regional office or the National Assembly for Wales for information and to ensure that coverage of national or regional policy issues is accurate.

WEEK 24

Once the trust is satisfied that the report is factually accurate, it is ready for publication. It is a public document which CHI publishes in hard copy and on its website. CHI gives the trust at least five days' notice of the publication date of the report. CHI's communications team provides support to the trust, if requested, in media handling and other aspects of communication.

6 After the review

The review process ends with the publication of CHI's report. However, progress towards successfully implementing clinical governance is itself an ongoing process in which CHI plays a continuing role.

Objective setting

Six to eight weeks after the clinical governance review visit, CHI jointly facilitates a day-long workshop with the trust. The aim is to help the trust think through how to take forward CHI's report, to identify its priorities for action and to translate them into achievable and measurable objectives. Representatives of the health authority and the regional office or the National Assembly for Wales take part in the workshop, as do other organisations within the local health community if invited by the trust.

The precise agenda for the day and the participants varies between trusts according to specific circumstances and the areas for action that CHI has identified in the report. The event gives the trust the opportunity to identify, in partnership with local stakeholder organisations, the best ways of achieving change.

Follow up

Following the workshop, the trust draws up an action plan setting out its objectives with how and when it plans to achieve them. It sends the action plan to the regional office or the National Assembly for Wales for comment and approval. CHI also receives a copy for comment. In England, the regional offices are responsible for signing off action plans arising from clinical governance reviews and in Wales the National Assembly agrees and signs off the plans. The trust publishes its action plan as close as possible to the publication of the CHI report. When the action plan can not be published at the same time as the report, the regional office or the National Assembly for Wales ensure that the trust has agreed a publication date.

The trust is responsible for taking forward the actions identified in the action plan. Regional offices in England and the National Assembly for Wales are responsible for managing the performance of trusts and supporting the implementation of action plans arising from clinical governance reviews.

Glossary

Audit A review that establishes how well a service meets pre-determined standards or criteria

Clinical audit The continuous evaluation and measurement by health professionals of how far they are meeting standards that have been set for their service (standards can be set by health professionals, themselves, or others). Successful clinical audit also involves changing practice to meet the standards

Clinical effectiveness For individuals, this means the degree to which a treatment achieves the health improvement for a patient that it is designed to achieve. For whole organisations, it means the degree to which the organisation is ensuring that 'best practice' is used wherever possible

Clinical governance The DOH document *A First Class Service* defines clinical governance as "a framework through which NHS 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" (it is about the systems the organisation has for ensuring high quality care)

Clinical governance review A systematic review of the arrangements an organisation has put in place to implement clinical governance

Clinical governance review report CHI's published findings of each clinical governance review which are available to the public. The purpose of the report is to identify areas for improvement and to encourage the spread of good ideas. It does not cast judgement on members of staff and it does not classify the quality of care provided

Clinical indicators Selected measurements of clinical care which help NHS staff to judge how well they are doing. Government publishes some of these annually

Clinical information Any information about treatments or services which can be used by patients or health professionals to help take decisions about patient care

Clinical risk management The systematic use of information and expertise of individuals within the organisation to identify and reduce clinical risks to patients

Community health council (CHC) A statutory body sometimes referred to as the 'patients' friend'. CHCs represent the public interest in the NHS and have a right to be consulted on health service changes in their area

District auditors The external auditors for all NHS trusts, local authorities and other bodies

Health authority (HA) A statutory NHS body responsible for assessing the health needs of the local population, commissioning health services to meet those needs and working with other organisations to build healthy local communities

Health economy The collection of organisations that plan and provide health services in an area including health authorities, NHS trusts, primary care groups and voluntary health organisations

Investors in People Investors in People is a national quality standard which sets a level of good practice for improving an organisation's performance through its people

Lay member A person from outside the NHS who brings an independent voice to CHI's work

Local health groups These exist in Wales only. They bring together family doctors, community nurses and others involved in health care. They contribute to local health improvement programmes and are taking on responsibility for spending on hospital and community health services, general medical services and prescribing

National Assembly for Wales The devolved tier of government in Wales

National data sets A standard set of data items (statistical evidence), concepts and definitions to enable the production of national and nationally comparable data

National indicators Statistics recorded by the Department of Health (DoH) on a range of specific treatments to allow comparison and measurement of NHS organisations

NHS trust A self governing body in the NHS which provides health care services. They employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc. (Acute trust – provides medical and surgical services usually in hospital)

Orthopaedics A branch of surgery interested in disorders and treatment of the spine and repair of joints and bones

Performance indicators Nationally agreed standards and measures to indicate how well an organisation is performing

Postgraduate deaneries Postgraduate deans commission, manage and develop postgraduate medical and dental education. They are responsible for the training of all medical and dental trainees within their region or part of a region (deanery)

Primary care trust (PCT) Primary care trusts are self-governing bodies that will evolve from primary care groups. They will have the same functions as primary care groups but will also commission some hospital-based health care services for their population and directly provide community health services

Primary care group (PCG) Primary care groups are committees of health authorities. They are groups of GPs, nurses and other health professionals working together to improve the health of local people, develop primary and community services and commission secondary care

Qualitative Data than can not be expressed using numbers, e.g. interview statements, diagrams, documents

Quantitative Data which can be measured in terms of numbers

Regional office There are eight regional offices of the NHS executive in England. They are responsible for the strategic management of the NHS and monitor the performance of health authorities and NHS trusts. They are part of the Department of Health; the people who work there are civil servants

Sampling technique A way of selecting a small group that is representative of a bigger group or the total population

APPENDIX A

Contact details

Commission for Health Improvement

For further details about clinical governance reviews, please contact one of the following:

David Bawden – Development Manager

Steve Collins – Assistant Director

John Dennis – Assistant Director

Karen Wright – Development Manager

At:
Commission for Health Improvement
Finsbury Tower
103-105 Bunhill Row
London EC1Y 8TG
Telephone: 020 7448 9200
Fax: 020 7448 9222
Minicom: 020 7448 9292

Or:
E-mail CHI at the following address:

information@chi.nhs.uk

You can also consult CHI's website, which includes a full description and a complete range of documents relating to the clinical governance review process, and other information about CHI's work at:

www.chi.nhs.uk

The NHS Clinical Governance Support Team (CGST)

CGST runs a series of unique programmes to support the implementation of clinical governance 'on the ground'. Clinical governance is the framework which helps NHS organisations provide safe and high-quality care. Fundamental to making this happen is creating and enabling a cultural change within the NHS. Through its innovative programmes, the support team enables a wide variety of NHS organisations to involve staff and patients in improving services and to continue to do so. Clinical governance is about changing the way people work, demonstrating that leadership, teamwork and communication is as important to high-quality care as risk management and clinical effectiveness.

For further information about its work in England please contact:

Clinical Governance Support Team
2nd Floor, 6 Millstone Lane
Leicester LE1 5ZW
Telephone: 0116 261 9062

Or access its website at: www.cgsupport.org

The Clinical Effectiveness Support Unit (CESU)

CESU closed at the end of March 2001. An Assembly-based NHS Wales Clinical Governance Support Unit is now being established as part of the NHS Quality Division.

For further information about its work in Wales please contact:

Clinical Governance Support and Development Unit – Wales
NHS Quality Division
National Assembly for Wales
Cathays Park
Cardiff
CF1 3NQ
Telephone: 029 2080 1147

Or access its website at: www.cesu.wales.nhs.uk

APPENDIX B

Pilot sites

CHI piloted the review process in full at four pilot sites, starting in April 2000. They were:

Southampton University Hospitals NHS Trust

City Hospitals Sunderland NHS Trust

North West Wales NHS Trust (Bangor)

Chesterfield and North Derbyshire Royal Hospital NHS Trust

We are very grateful to the management and staff of all four trusts for their help in developing the review and in our evaluation of the review methods.

APPENDIX C

Review issues

Consultation and patient involvement

1 Commitment to communication with patients* and understanding of their needs and priorities, and the structures and accountabilities to lead this

2 Mechanisms to involve patients, or their representative organisations, in the planning and monitoring of services:
- public participation groups
- lay/citizen representation on trust board and clinical governance committees
- public consultation exercises
- use of validated instruments to find out patients' views

3 Co-ordination of the strategy and programmes for consultation and patient involvement and integration with the wider quality improvement programme

4 Training in patient (customer) care, communication skills, confidentiality issues

5 Training for staff in complaints handling

6 Processes to involve patients in the planning and delivery of their care, including consent to treatment and agreement not to resuscitate

7 Availability of information for patients and carers about treatments, services and facilities

8 Processes for patients and carers to voice concerns, issues and compliments about services

9 Processes for dealing with informal and formal complaints from patients and carers and action taken to prevent their recurrence

10 Arrangements to find out about, and meet, patients' needs:
- cultural
- spiritual
- disability
- dietary

11 Arrangements to ensure patients' rights to privacy, dignity and confidentiality about themselves and their treatment

* Patients/users

Clinical audit

1 Commitment to the management and direction of the clinical audit programme, and the structures and accountabilities to lead this

2 Reporting of audit results and the impact of clinical audit on changes to practice

3 The extent to which clinical audit work goes across organisational boundaries – for example, involves primary care and social services

4 Co-ordination of the strategy and programmes for clinical audit, priorities for clinical audit, and integration with the wider quality improvement programme

5 Involvement of patients or carers in clinical audit

6 The involvement of staff and the extent to which there is a team-based approach to clinical audit project identification, design, implementation and evaluation

7 Availability and uptake of training and development in audit skills

8 Support and resources for clinical audit and systems for audit approaches and methods

9 Learning from clinical audit including:
- the extent to which clinical audit results in sustained change and improvements to service plans and to patient care
- the extent to which clinical audit activity leads into and develops research questions

10 Participation in confidential enquires and national audits (according to NICE priorities and guidance)

Clinical risk management

1 Commitment to the management and direction of the clinical risk management programme, and the structures and accountabilities to lead this

2 Promotion of an open, blame-free culture for reporting incidents and near misses

3 Communication of requirements of staff to report risks and incidents (including induction training), and the measures they must take to prevent and control risks – for example, infections and pressure sores

4 Involvement of partner organisations in clinical risk management for patients whose care is provided by a number of organisations

5 Co-ordination of the strategy and programmes for clinical risk management and systems for collecting and bringing together all information about risks

6 Systems for assessing clinical risks

7 Systems for reporting clinical incidents and near misses

8 Strategies and support for preventing and managing identified clinical risks – for example, use of trigger events, protocols for dealing with specific incidents

9 Learning from knowledge about clinical risks:
- systems to identify trends in incidents and to take action on them
- consideration of clinical risks in service decisions
- dissemination of information about risks and incidents

10 Notification of specific serious clinical incidents to the regional office/National Assembly for Wales

11 Performance – for example, the number of incidents reported, occurrence of infections, occurrence of pressure sores (performance indicators to be determined)

12 Attainment of external risk management standards – for example, Clinical Negligence Scheme for Trusts (CNST)

Research and effectiveness

1 Commitment to the management and direction of the research and effectiveness programme, and the structures and accountabilities to lead this

2 The importance placed on implementing and monitoring evidence-based practice

3 The extent to which research work goes across organisational boundaries – for example, the involvement of primary care, social services and educational organisations

4 Co-ordination of the strategy and programmes for research, priorities for research and effectiveness work and integration with the wider quality improvement programme

5 Involvement of patients and carers in research project identification, design, implementation and evaluation

6 Involvement of staff and the extent to which there is a team-based approach to research project identification, design, implementation and evaluation

7 Access and support for staff in the development of skills in research and evidence-based practice – for example, critical appraisal skills training

8 Access to research results and evidence of effective practice by clinicians

9 Learning from research:
- mechanisms to make operational effective practices – for example, evidence-based guidelines for disease management
- the extent to which research results in sustained change and improvements to service plans and to patient care

- identification of performance indicators from research results
- dissemination of the findings of research

10 Compliance with NICE guidelines, National Service Frameworks (NSFs) and other agreed national guidelines

Staffing and staff management

1 Commitment to the management and direction of the staffing and staff management issues and the structures and accountabilities to lead this

2 Communication to staff of their own responsibilities and accountabilities and reporting arrangements

3 Monitoring and reporting of key performance indicators – for example, staff sickness rates and action taken to tackle problems

4 Joint approach to those aspects of care delivery where there is close partnership working with other organisations – for example, discharge arrangements

5 Human resources strategy which links with clinical governance and delivers national priorities – for example, Working Together and Improving Working Lives targets

6 Processes for workforce planning, linked to service planning, that incorporate current and future skill requirements and turnover

7 Human resources processes, including recruitment and the promotion of equality of opportunity and good race relations

8 Systems and support for:
- induction
- appraisal & personal development planning
- clinical supervision
- dealing with cases of poor performance

9 Arrangements to ensure deployment of appropriate staffing and skills:
- minimum 'safe' numbers and mix
- schemes of delegation and supervision – for example, operating at night
- protocols for staff working in extended roles – for example, nurse prescribing

10 Team working within teams – for example, multidisciplinary team working, handover arrangements, ward rounds, case conferences

11 Team working between teams – for example, handover on transfer of patients, access to specialist advice, arranging discharge of patients

12 Employee support services – for example, occupational health services, support against bullying and harassment

13 Learning from staff – for example, through staff attitude surveys, staff appraisal and feedback processes, exit interviews

14 Risk assessments and management strategies to tackle accidents and violence to staff, and issues of workplace health, safety and ergonomics

15 Compliance with directives on working time

16 System to ensure that clinical staff registration and qualifications are checked on appointment and at time of revalidation

17 Staff well being and satisfaction (performance indicators to be determined)

18 Performance – for example, staff sickness rates, staff turnover (performance indicators to be determined)

19 Attainment of external human resource standards – for example, Investors in People

Education, training and continuing personal and professional development

1 Commitment to education, training and continuing professional development (CPD) and the structures and accountabilities to lead this

2 Involvement of partner organisations in education, training and CPD:
- partnerships with educational establishments
- joint training with staff from other health and social care organisations where there is partnership working

3 Co-ordination of the strategy and programmes for education, training and CPD linking in with broad training and development plans

4 Opportunities for, and participation by, staff and multidisciplinary teams in work-based training

5 Opportunities and support for, and participation by, staff in CPD programmes

6 Opportunities and support for obtaining professional, or further, qualifications

7 Support for staff undergoing formal education

8 Systems to ensure that mandatory training requirements are met – for example, cardio-pulmonary resuscitation (CPR), moving and handling

9 System to ensure that results of external assessments of training and education programmes are considered and acted upon

10 Performance – for example, percentage of staff trained in CPR (performance indicators to be determined)

11 Attainment of external standards/accreditation – for example, Investors in People, Royal Colleges etc

Use of information to support clinical governance and health care delivery

1 Responsibility and accountability for the development and use of information about the patients' experience

2 Scope of available information about the patients' experience

3 Priority given to information management and technology (IM&T) in strategic plans for clinical governance and to the needs of clinical governance in strategic plans for IM&T

4 Involvement of partner organisations in the development, collection and use of information about the experience of patients whose care is provided by a number of organisations

5 Communication of information about individual patients between GPs and hospital staff

6 Access to information – for example, through the information technology infrastructure, health care records

7 Communication of information about individual patients within teams and between teams

8 Use of information to inform service strategies and plans, to support performance review and improvement and to inform clinical governance activities

9 Access for staff to training and support in access to and use of information

10 Systems for assuring data quality

11 Compliance with information requirements of the NHS – for example, national patient surveys, patient charter, hospital episode statistics (HES), common information core, NSFs

12 Compliance with requirements to keep patient information confidential

APPENDIX D

Role of the trust co-ordinator

What is a trust co-ordinator?

The trust co-ordinator plays an important role in the success of the Commission for Health Improvement (CHI) clinical governance review. He or she acts as the main point of contact between our review team and your trust, assisting with collecting information, planning the review, and helping ensure the visit runs smoothly. Their help will be much valued by the review team.

Who should be a trust co-ordinator?

Trust co-ordinators should be identified by your trust. The co-ordinator will need to have an understanding of how your trust operates as a whole and knowledge of clinical governance in the organisation will be helpful. The co-ordinator will also need good organisational skills, and will be supported by CHI's review manager throughout the review process.

We estimate that a trust co-ordinator will need to spend around 20–30 days helping with the preparation of the review. They will also need to be available during the review visit to assist with any queries, and will have some involvement during the reporting and action-planning stages.

What does a trust co-ordinator do?

Trust co-ordinators assist in the three main stages of a review – preparation, the site visit and reporting. There will also be some involvement afterwards, in assisting with action planning.

During the preparation stages, we ask the trust co-ordinator to publicise the review to staff and patients. CHI will work closely with your communications people to supply methods of publicising the review. We also ask that the trust co-ordinator ensures that all information requested by CHI is sent to the review team on time. The trust co-ordinator will be asked to help with the practical arrangements for the review – such as scheduling, and arranging work areas and catering for the review team whilst they are at your trust. CHI will organise the reviewers' overnight accommodation.

During collection of the data and documents requested by CHI as part of the review, the trust co-ordinator will have a key role. We will give the trust co-ordinator a checklist to help them through the review process which they will be required to complete and return. This checklist will log and identify

every document the trust will return to CHI. Full instructions for completion of this checklist are supplied within the 'pre-visit request for existing data and information'.

During the review visit, the trust co-ordinator will be asked to assist in any logistical arrangements, such as accompanying the review team members from appointment to appointment and re-arranging interviews if necessary.

After the review visit, the trust co-ordinator should co-ordinate comments on the factual accuracy of CHI's draft report, and assist with the action planning for your trust.

What information is available for the trust co-ordinator?

At the initial start-up meeting, CHI will clarify the information that needs to be collected, key dates and the entire review process. The trust co-ordinator will also be given a 'mock time-table' to use as a basis for scheduling meetings and visits during the review visit.

Throughout the review, CHI review managers will work very closely with trust co-ordinators and will be able to help with any queries.

For more information on the role of the trust co-ordinator, please contact your CHI review manager.

Patient diary – access to care

COMMISSION FOR HEALTH IMPROVEMENT (CHI)
CLINICAL GOVERNANCE REVIEWS

Patient diary 1 – Access to care

Serial number ☐

Thank you for agreeing to fill in this diary.

By filling in this diary you are giving your consent to participate.

After you have completed the diary, please return it direct to the CHI review team in the pre-paid envelope provided. Please return it within 14 days of receipt.

If you do not want to take part in the survey, please tick the box and return the blank diary in the envelope provided. ☐

We are interested in the things that are important to you. We want to know about your experience and how you were treated – both good experiences, and areas where things could be better.

Patients in other surveys often mention some of the things listed below, and this list might help jog your memory.

- the way you were treated by staff around the hospital
- getting to see a doctor, nurse or other professional
- arrangements for any tests or investigations you needed
- the treatment you had, or the way you were referred to a different professional
- the information, explanation and reassurance you were given
- whether your doctor or nurse had all the information they needed about you
- whether things happened in the way you expected
- whether you knew what was going on

But remember, you only need to write about the things that are important to you.

Use this section to write about things that happened to you while you were looked after by the hospital, and how you feel.

You could start by writing what happened when you found you had to go to hospital, and the things that have happened since then.

We are interested in the things you were pleased with, as well as the things that could have been better. You can also write about how you feel when nothing is happening with your health care.

Please include anything you would like to say about your health care overall. Write as much or as little as you like.

Date What was really good about your care?

Date What really needed improvement?

Is there anything you would like to say about your health care overall?

APPENDIX F

Indicative timetable for site visit

DAY	AM	LUNCH	PM	EVENING
MONDAY	Arrive at trust Meet with trust coordinator Orientation to trust Meet executive team/ members of trust board Trust to present an overview of clinical governance arrangements and future priorities to the review team. Discussion to follow.	Lunch meeting for team	Work in clinical teams begin Clinical team to present an overview on how clinical governance is making a difference to their patients Clinical team member interviews Observation periods	Possible night visit Debriefing session
TUESDAY	Clinical teams	Lunch meeting for team	Clinical teams	Possible night visit Debriefing session
WEDNESDAY	Clinical teams	Lunch meeting for team	Clinical teams	Possible night visit Debriefing session
THURSDAY	Clinical teams	Lunch meeting for team	Interviews with members of the corporate team – for example, chief executive, director of nursing, medical director, director of human resources, director of postgraduate medical and dental education	Debriefing session
FRIDAY	Corporate interviews continued Additional interviews Revisits Completion of site visit recording forms	Lunch meeting for team	Final meeting with members of the trust board and staff who attended the start-up meeting	

APPENDIX G

Outline report structure

Foreword

Clinical governance and reviews

- what is clinical governance?
- clinical governance reviews

Executive summary

Chapter 1 Introduction

Chapter 2 The trust's context

Chapter 3 The patient's experience

- clinical effectiveness and outcomes of care
- access to services
- organisation of care
- humanity of care
- the environment

Chapter 4 Use of information

- information about the patients' experience
- information about resources and processes

Chapter 5 Resources and processes

- processes for quality improvement
  - consultation and patient involvement
  - clinical risk management
  - clinical audit
  - research and effectiveness
- staff focus
  - staffing and staff management
  - education, training and continuous personal and professional development

Chapter 6 Strategic capacity

Chapter 7 Action following the review

Appendices

A The review team
B Sources of evidence
C CHI's assessments of clinical governance
D Glossary

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