



INHEALTH NETCARE

LONDON DIAGNOSTICS SCHEME

STRATEGIC FRAMEWORK FOR CLINICAL GOVERNANCE

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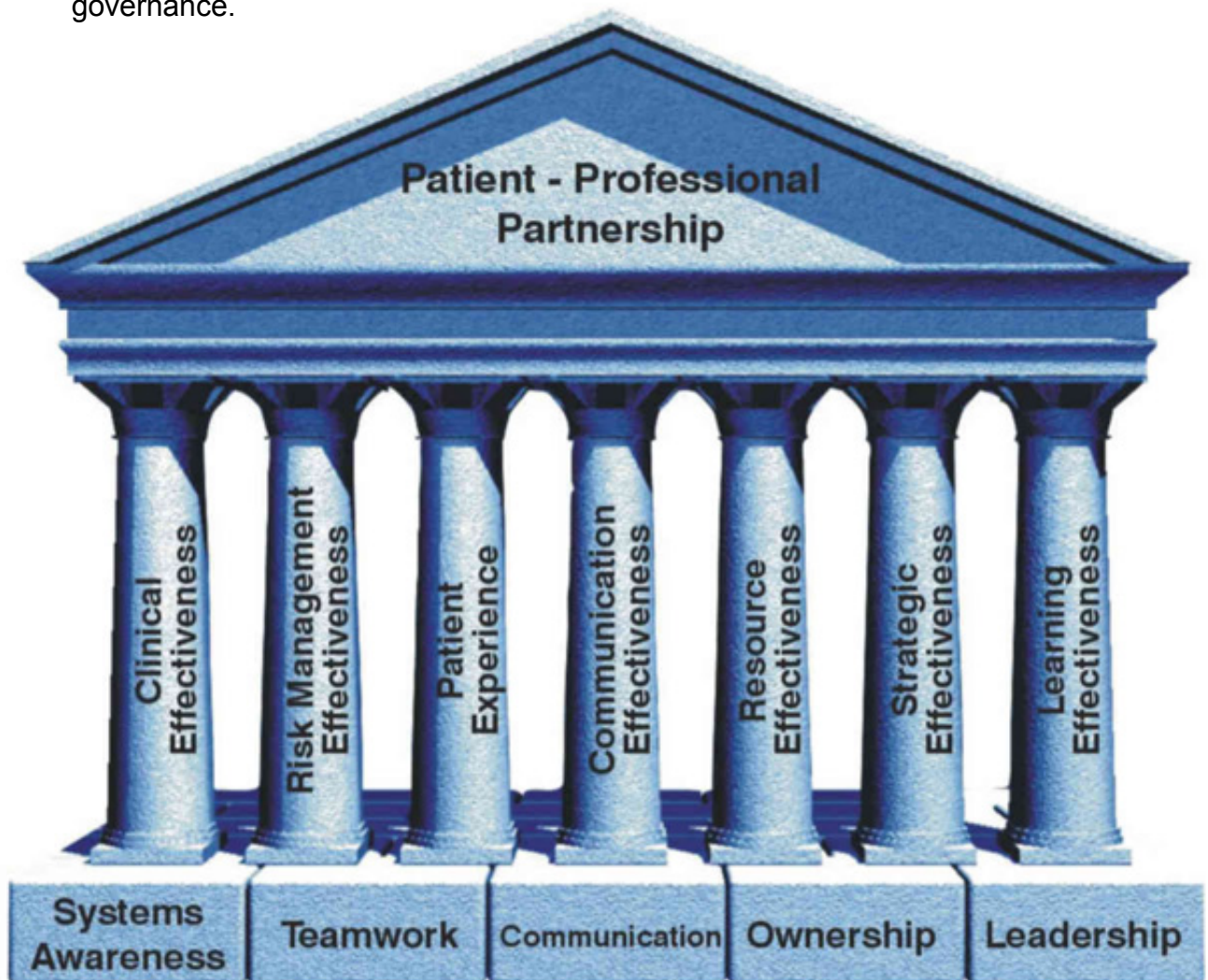
Clinical Governance Framework for the London Diagnostics Scheme

Introduction

Clinical Governance is the *'framework'* through which InHealth Netcare is accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. (A first class service: Quality in the new NHS, Department of Health 1988) It forms the central part of policy to maintain and improve quality in healthcare

Seven Pillars of Governance

The temple paradigm is a model that illustrates the *seven pillars* of clinical governance.



The peak of the temple is the patient-professional partnership, which is at the

Delivering diagnostics to the heart of the community



heart of clinical governance; this is supported by the processes represented by the seven pillars, the effectiveness of which can be measured with specific tools.

The foundations for the pillars are cultural components of systems awareness, teamwork, communications, ownership and leadership. Shared beliefs, attitudes, values and norms of behaviour around these components can provide a sustainable enabling culture where quality can flourish.

EXECUTIVE SUMMARY

Clinical Governance is about ensuring that clinical care is delivered to the highest standards in accordance with current knowledge and guidance. It is a statutory responsibility for all organizations delivering healthcare, and a responsibility for all individuals within those organizations.

The delivery of high quality clinical care is at the heart of the InHealth Netcare Strategic Framework. This requires a culture of openness, effective practice, lifelong learning, the management of safe practice and involving patients as partners in their care.

This strategic framework describes how InHealth Netcare will support staff to deliver the right care to the right patient at the right time, in the right place. Through a process of involvement and consultation this framework has been developed to set out the requirements from groups of healthcare workers within InHealth Netcare in delivering Clinical Governance. This framework also sets out the processes for clinical governance and where these fit into corporate and local initiatives. It also refers to the tools provided for effective clinical governance.

The overall aim is to provide guidance for the actions that should be taken to achieve sustainable and robust clinical governance.

Strategic Aims

Clinical Governance within InHealth Netcare will:

- Provide a framework where everybody assumes responsibility for the quality agenda
- Establish a positive, no blame culture;
- Support staff to achieve their potential through lifelong learning and continual professional development;
- Achieve continuous improvements in patient care, which is safe, effective, timely, efficient and equitable;

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- Adopt a patient-centred approach that includes treating patients courteously, involving them in decisions about their care, keeping them informed and learning from them;
 - Minimize risks and hazards to patients and staff, with a commitment to learn from mistakes, and to share that learning;
 - Reduce variations in the process, outcomes and in access to health care;
 - Ensure health professionals are up to date in their practices;
 - Empower clinical staff to improve the quality of care;
 - Encourage and support clinical leadership;
 - Promote evidence-based clinically effective patient care, the systematic adoption of good practice and research evidence and channel innovation;
 - Recruit, develop and educate the right number of well-trained and motivated staff with appropriate skills and experience;
 - Strengthen multi-disciplinary team working;
 - Manage poor performance effectively;
 - Involve local people in the development and planning of local health services;
 - Be open and transparent to all stakeholders.

The scope of this document is the InHealth Netcare London Diagnostics Scheme

Accountability and Responsibility

Responsibility for governance rests with the InHealth Netcare Joint Venture Board. This board is comprised of Directors of both InHealth and Netcare.

It is the responsibility of all InHealth Netcare staff to consider the components of Clinical Governance and take steps to achieve these strategic aims.

The Clinical Director has overall responsibility and accountability for Clinical Governance within InHealth Netcare. In addition to that, the following delegations of responsibility have been made:

The Quality and Risk Manager, who is a member of the senior management team, will have operational responsibility for the development, implementation

and maintenance of a Clinical Governance Strategy. She will have day-to-day responsibility across all areas of governance and will work with the modality leads to ensure that there is a consistent approach.

Clinical audit will be driven by the Quality and Risk Manager who will act as an ambassador for Governance across the organization. They will also ensure that the sub-contractors to the service fulfill the contractual components of Clinical Governance in developing and delivering their services.

Clinical Leads

Modality/clinical leads will have corporate responsibility to ensure that InHealth Netcare fulfils its obligations through:

- Establishing and implementing a Clinical Governance Plan to develop and maintain the quality of services
- Facilitating delivery of the requirements of the Clinical Governance Plan
- Ensuring that the recommendations from professional or legislative bodies are implemented in a timely manner
- Ensuring that all sites are engaging in clinical governance and producing the appropriate reports on time.
- Ensuring that a monthly, minuted Clinical Quality meeting is held and that all staff attends at least 50% of these meetings in a year.

Clinical Governance Committee

A sub-committee of the JV board is the Clinical Governance Committee which meets bimonthly. This committee is chaired by the Clinical Director or the Quality and Risk Manager and attended by all the clinical leads and operations directors. The membership is detailed in Appendix 1.

The Clinical Governance Committee is responsible for the receipt and management of Clinical Governance Reports from all the units within the diagnostics service. The committee receives this information and is responsible for the following:

- A review of staff appraisal, recruitment and competency assessment.
- Management of poor performance
- An overview of Clinical audit and clinical outcomes
- A review of the contract KPIs and action planning surrounding outliers
- An overview of clinical incidents, near-misses complaints and serious untoward incidents
- A review of education and training
- Review of clinical risk management processes across the London Diagnostics scheme

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- Review of Infection Control procedures and surveillance results
 - Review and updating to reflect changes in practice or through Royal Colleges and legislation that may impact on care pathways
 - Ensuring Clinical Effectiveness
 - Patient Satisfaction and staff satisfaction
 - Monitoring of Continuing professional development
 - Clinical leadership
 - Health and Safety

Minutes of the monthly quality meetings are sent to the Quality and Risk Manager and a record of attendance kept to ensure at least 50% attendance from all staff .

A pro-forma for the monthly clinical governance report is provided to each clinical lead to include:

- Recruitment and competency assessment of staff
- Results of audits – clinical and external
- New procedures and protocols
- Incidents
- Complaints
- Patient Satisfaction
- Out of line indicators and KPIs – rectification plan
- CPD and training events set up and attended

Management of research.

InHealth Netcare will not participate in clinical research trials as part of this contract. Where the Clinical Governance Committee and the JV board believe that participation in research is justified and such an application for research has been made, an ethics committee will need to be established for approval of projects.

Independent Clinical Advisory Board

In order to establish effective liaison between the NHS and the independent sector and provide the Independent sector with advice in order to deliver services which are relevant and based on the best possible current practice, we have established an Independent Clinical Advisory Board. The members of this board are all specialists and consultants who work for the NHS but are able to provide sessional work of a non clinical nature for InHealth Netcare. As this is a service to provide access to diagnostics for General Practitioners and we are including four GPs in our advisory board. This will ensure that our referral, testing and reporting procedures are meeting the needs of GPs.

The characteristics of a specialist adviser are –

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1. a respected and experienced NHS or academic consultant, specialist or general practitioner ;
 2. a willingness to provide support in the development of the independent sector treatment program;
 3. experience in appraisal and training;
 4. the ability to provide some dedicated time to the post.

The Clinical Advisory board will be composed of members who can advise the InHealth Netcare clinical team and the JV board on:

1. recruitment and assessment of new staff working for InHealth Netcare;
2. clinical staff appraisal
3. audit and clinical governance
4. research;
5. training programmes for NHS staff;
6. specialist clinical advice on clinical service delivery
7. national policy and guidance
8. needs of the NHS for services or changes in service
9. investigation of incidents

The board membership is detailed in Appendix 2.

Meetings will be held quarterly

Sub Contractors responsibility and accountability

InHealth Netcare is working with two key sub-contractors to deliver diagnostic services. These are BMI Healthcare and InHealth Diagnostics. Both these organisations have their own Clinical Governance Structures and have embedded structures for management of all governance areas. It is the responsibility of the Clinical Risk manager to ensure that coordination of activities between InHealth Netcare and its subcontractors takes place. The internal clinical governance processes within BMI and InHealth will feed into the InHealth Netcare structures to ensure that robust governance supports the clinical safety and effectiveness of the contract.

Caldicott Guardian

The Caldicott Guardian is the Clinical Director and has responsibility for ensuring that a structured plan is put into place across InHealth Netcare and for monitoring that plan.

External Quality Assurance of equipment and laboratories.

All equipment will be quality assured by an appropriate expert, in the case of diagnostic imaging and ultrasound by a medical physics team such as North West Physics. All laboratories used will be CPA accredited.

All electrical equipment will be portable appliance tested (PAT) either by in-

house staff or an external tester.

Clinical Risk Assessment and Management

The Quality and Risk manager will be responsible for training our clinical and managerial staff in this area and reporting on clinical and business risk to the JV board.

Clinical risks identified will be discussed at the local site meetings and where appropriate will be escalated to the next level committee. Issues requiring urgent resolution will be discussed with the quality and risk manager and actions to resolve them will be implemented as soon as practicable. Where shared learning can take place, issues will be discussed at the Clinical Governance Committee meeting and communicated to all relevant sites.

Education and Training

We are committed to the training of NHS staff and undergraduate students in line with our contractual requirements. The InHealth Netcare diagnostic service is keen to be involved in the provision of training for undergraduate radiographers

There is a Training Board attended by the Heads of Radiography of the 4 London Universities providing Radiography training , the InHealth Head of Training , the InHealth Netcare Clinical Director and Salma Hasnain – radiographic advisor to InHealth Netcare . This board is responsible for the development of a programme of training for MRI radiography. Our cost neutral training strategy was submitted previously and accepted by the DH.

Clinical Accountability and Quality Management

The management structure for the London Diagnostics project has been redesigned to ensure that there are experienced clinicians available to take responsibility for the operation and delivery of services and also the management of quality and risk and within the scheme. It is therefore proposed that the London Diagnostics scheme has a Clinical Director with ultimate responsibility for the delivery of clinical services. Working with the Clinical Director are operations managers and clinical leads with responsibility for delivering the clinical operations of the joint venture, the diagnostics and imaging service, the reporting house contract and the BMI services contract. The Quality and risk Manager is responsible for the establishment and ongoing performance of clinical audit, governance and quality groups across the scheme. They will be also responsible for ensuring the clinical KPIs are collected, analysed and interpreted and that regular reports are available to the Independent Clinical Advisory Board, Joint Venture Board, Clinical Governance Committee and NHS Joint Service Reviews.

Initial Competency assessment and continuing professional

development

All staff are recruited and assessed using the competency frameworks and assessments approved by the DH workforce group. We use external assessors as well as our own assessors and appraisers who are all experienced in appraisal.

Our clinical leads will carry out an annual appraisal of the clinical staff in their service. Each clinician will have a personal development programme and maintain a CPD portfolio. All staff are expected to participate in clinical governance and attend meetings as appropriate. Opportunities will be made available to attend journal clubs, peer review meetings and self-directed learning to maintain their practice. In addition, a programme of mandatory training in line with legislation is required to be attended by all relevant staff.

Requirements of professional regulatory bodies will be achieved. Funding may be made available for study leave where appropriate and some staff may be funded to attend external conferences and courses. On line training modules will be accessible via the intranet.

Clinical Audit

Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

Aspects of the structure, processes and outcome of care are selected and systematically evaluated against defined criteria. Where indicated, as a result, Changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery (Principles for Best Practice in Clinical Audit, National Institute for Clinical Excellence 2002).

Patient Involvement

Every patient will be offered the opportunity of completing a patient satisfaction questionnaire. The results of these are collated and reports will be made available to the sites, the Quality and Risk Manager and the JV Board.

Following receipt of reports, action plans to address any areas of concern should be developed and implemented, responsibility for this rests with the clinical governance lead for each modality at each site.

InHealth Netcare are also keen to participate in public consultation meetings held by the PCT and GP forums. Any information received from PCTs, GPs or other referrers in relation to patient satisfaction will be shared through this route.

Untoward Incidents and Complaints

All serious clinical incidents will be reported and investigated in line with the DH Policy for SUIs.

All clinical incidents will be reviewed at site meetings and where deemed appropriate they will be escalated to the Quality and Risk Manager for actions to be defined.

Complaints will be addressed in line with the InHealth Netcare complaints policy. A Summary of complaints will be discussed at the meetings within sites and modalities and also at the Clinical Governance Committee meetings.

This Framework should be read in conjunction with the following policies:

InHealth Complaints Policy

InHealth Netcare Risk Management Policy

InHealth Incident Reporting Policy

The protocol for Urgent Onward referral of a patient.

The protocol for managing an emergency condition (999 pathway)

InHealth Infection control policy) including needlestick injury procedure and Isolation procedure)

All policies are incorporated in the integrated governance framework for InHealth Netcare.

Recruitment and Competency Assessment of staff.

Clinical Audit and governance arrangements.

Each modality has a recruitment and competency assessment process and clinical audit programme based on current best practice in the NHS and private sector, which includes analysis and review of the contracts KPIs.

Endoscopy

Recruitment and competency assessment

Endoscopy services will be carried out entirely on BMI hospital sites in London. Six hospitals will be providing access to patients to flexi-sigmoidoscopy services. Patients will receive information from the Patient Referral Centre regarding their pre-intervention bowel preparation etc. together with their patient information leaflet. The team of staff performing endoscopy comprises the following:

- i Consultant surgeons and gastroenterologists who have practising privileges at the BMI hospital and are NHS consultants

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- ii Endoscopy nurses who have been trained as endoscopy nurses and work in the BMI hospital
 - iii Healthcare assistants who will normally be members of the endoscopy team at the BMI hospital

All these staff also work for the BMI hospital and will have been involved in the recruitment, accreditation and continuing professional development arrangements for the BMI Group.

In particular, the consultants will have as part of the process for being involved in this scheme have demonstrated that they have performed at least 200 endoscopies over the past 12 months of which at least 50 must have been flexi-sigmoidoscopies or an investigation of similar complexity.

Mr Ian Swift, a consultant surgeon based at Mayday Hospital who also works at Shirley Oaks Hospital, is taking responsibility for the leadership of consultants performing endoscopy. He will be involved in the audit of endoscopy using the GRS system and also will be a member of our independent advisory board.

Audit and Governance

In each BMI hospital there is an identified manager / endoscopy nurse who is taking the lead for clinical governance. These individuals have been identified and will meet regularly with the endoscopy lead manager, who has been given additional responsibilities to prepare an overview of the GRS reports from each of the BMI hospitals. In addition to this, they will be available to advise and support colleagues in the other five BMI hospitals on a day to day basis.

Each BMI hospital has established a system for recording the GRS (Global Rating Score) and also for the collection of other indicators which are part of the key performance indicators (KPI) for this scheme. In line with contractual requirements, the GRS will be maintained at a level that achieves at least 75% of A ratings.

The agreed endoscopy for KPIs are listed below.

ENDOSCOPY KEY PERFORMANCE INDICATORS

Project agreement auditable outcomes

Endoscopy Global Rating Scale (GRS) $\geq 75\%$ at level A

Endoscopists should achieve a Patient Safety Incident Rate of $<0.1\%$ measured over the preceding 12 month period

Quality and Safety Standards

Auditable Outcomes	Quality Standards	Safety Standards
<p>Sedation and analgesic doses</p> <p>Comfort levels</p> <p>Correct identification of position of cancers $>90\%$</p> <p>Performed and reported on minimum of 200 flexible sigmoidoscopies or equivalent complexity endoscopy within last 12 months</p>	<p>90% adjusted completion rate (with photographic evidence if IC valve)</p> <p>Adenoma detection rate $>10\%$</p> <p>Polyp recovery $>90\%$</p> <p>Tattooing of suspected malignant polyps 100%</p> <p>Good quality bowel prep $>90\%$</p> <p>Diagnostic colo-rectal biopsies for persistent diarrhoea 100%</p> <p>Biopsies for surveillance Irritable Bowel Disease >30.</p> <p>Tattooing of tumours if small or position not clear (100%)</p> <p>Acute complications medically stabilised and transferred to secondary care within 2 hours ($\geq 98\%$)</p> <p>Minor diagnostic error rate ($\geq 2\%$)</p> <p>Major (clinically significant) diagnostic error rate ($\geq 0.1\%$)</p>	<p>Colonoscopy perforation rates $<1:5000$ (0.02%)</p> <p>Post polypectomy bleeding requiring transfusion $<1:100$ (1%) (for >1 cm polyps)</p> <p>Post polypectomy perforation rates $<1:500$ (0.2%)</p>

Endoscopy KPI Reporting Table for the 6 BMI sites delivering the London Diagnostic contract

Table 1 – Specific Project Agreement

KPI	How is it reported	Person Responsible for collecting the data	Frequency	Sent to
DNA RATES ≤0.5%	Cosmic		Monthly	
Complication rate ≤0.5%	Endosoft and Sentinel	Individual Endoscopist and facility Clinical Governance Lead	Monthly	
Endoscopy Global Rating Scale (GRS) ≥75% at level A	On line audit tool	Department Manager	6/12	GRS
Endoscopists achieve a Patient Safety Incident Rate of <1% measured over the preceding 12 month period	Endosoft and Sentinel	Individual Endoscopist and facility Clinical Governance Lead	Monthly and 6/12 through GRS	

Table 2 – BSG Quality and Safety Indicators - General auditable outcomes audited by the Global Rating Scale

Auditable Outcome	How is it reported	Person Responsible	Frequency	Sent to
Unplanned admissions and operations	Sentinel	Department Manager	Monthly	
30 day mortality	By GP returning tear off slip on discharge letter	GP	As occurs	
Use of flumazenil	Endosoft	Individual Endoscopist	Data collated Monthly for CG report	Sent to GRS 6/12
Use of Naloxone	Endosoft	Individual Endoscopist	Data collated Monthly for CG report	Sent to GRS 6/12

Need for ventilation	Endosoft Sentinel	Individual Endoscopist Department Manager	Data collated Monthly for CG report	Sent to GRS 6/12
Perforation	Endosoft Sentinel	Individual Endoscopist Department Manager Director of Nursing	Data collated Monthly for CG report	Sent to GRS 6/12
Bleeding	Endosoft Sentinel	Individual Endoscopist Department Manager	Data collated Monthly for CG report	Sent to GRS 6/12
Sustained drop in O2 saturation <90%	Endosoft	Individual Endoscopist	Data collated Monthly for CG report	Sent to GRS 6/12

Each BMI hospital will report their GRS regularly and these will be incorporated in the KPI monitoring set. Within each BMI hospital the GRS scores will also be reviewed at the hospital's clinical governance committee and the hospital medical advisory committee.

Other key performance indicators which will be reported for the endoscopy service include (those of clinical relevance)

- late reports
- report turnaround times
- urgent reports
- clinical cancellation rates
- clinical performance rates
- completed examinations
- incomplete examinations
- rejections
- clinical rejections
- reasons for clinical cancellation
- reports completed
- reports outstanding
- clinical audit summary (GRS)
- endoscopy complication rate
- serious untoward incidents / patient safety incidents
- complaints
- breach of patient confidentiality
- satisfaction survey
- referring clinician satisfaction survey
- inbound queries from referrers chasing reports
- inbound queries on patient DI preparation leaflets

Histology reports

There is an expectation that about 10% of endoscopies will result in the referral of specimens for histology. These samples will all be sent to UHE and the turnaround time for reporting is 5 days and 3 days for urgent samples. Where a sample has been sent to histology the endoscopists will prepare preliminary report and on receipt of the histology results will provide the GP with a final report.

Suspected cancers

In any situation where the endoscopist has a high level of suspicion that the patient has a cancer an immediate communication will be made to the GP recommending the referral of that patient to the nearest cancer network using the usual local 14 day cancer referral process.

We anticipate that the results from the GRS system will be made available to the independent advisory board, the joint venture project board and other professional clinical meetings. Across the BMI hospital group it is anticipated that within the next twelve months all endoscopy will be audited using the GRS. This will mean that any patient referred within the Group whether this is through the London Diagnostics project or as a private patient will be included in the GRS audit. Within the BMI Group it is hoped that the results of this audit will be made available across the Group for comparative purposes and to encourage the sharing of outcome data and the improvement of performance.

All endoscopy will be carried out in accordance with the detailed clinical pathway and associated protocols which are in the Endoscopy Manual. This is available to staff at all BMI hospital Sites.

Phlebotomy

Recruitment and competency assessment

Staff have been recruited to carry out phlebotomy in a number of community and hospital settings. These clinicians have all been assessed using a competency framework and deemed to be competent to carry out phlebotomy unsupervised, on the basis of their previous experience and their assessed competency. Samples will all be sent to a local NHS or Independent laboratories in accordance with agreed protocols and contracts.

Audit and Governance

We have responsibility for the safe transit and receipt of samples and the relevant key performance indicator in this context is number of samples rejected by the laboratory. We anticipate that we will have feedback from the participating laboratories regarding the number of samples which they will reject and which we are required to repeat.

In addition to this, the relevant KPIs will be the number of serious untoward incidents or patient safety incidents. These will be recorded by the phlebotomists and investigated by the registered nurse with a responsibility for

the physiological measurements team. There will be a regular meeting of all the phlebotomists and healthcare assistants to review their activity and to review the protocols, procedures and outcomes for their clinical areas. In addition to that, it will be necessary to review the referrals by GP and the number of patients who do not attend or cannot have a completed test. This will form part of the regular audit of the phlebotomy service.

Echocardiography

Recruitment and Competency Assessment

All echo cardiographers employed by the service have been deemed competent by the British Society of Echocardiography They are assessed as fully competent in the following dimensions by an independent assessor:

- Their completion of the routine mandatory training and induction required for the project
- Their ability to use the equipment including the IT integral to the service
- Their ability to carry out and report on a range of techniques

Each echocardiographer will be required to complete, under supervision of an external assessor, ten standardised reports which include all the key measurements, key findings and a recommendation to the GP.

Echocardiographers will have access to the support and advice of a cardiologist who will also be able to assist them with the interpretation of images through the PACS system.

Where the echocardiographer is concerned that the procedure or report is beyond their competence, they will refer them to the cardiologist for a second opinion.

Where the echocardiographer sees an abnormality that requires urgent attention they will flag the report and the PRC will ensure that the GP is made aware of the condition. If the patient becomes acutely ill whilst they are having their echocardiograph carried out then the echo cardiographer will refer the patient for the management of their acute problem via 999 to a local A&E department.

Audit and Governance

A 10% independent audit is carried out by two London Cardiologists. The echocardiographers meet as a group monthly to review the audit and also to discuss interesting cases. The audit is based on the RCR categorisation of reports 1 – 5 - as detailed in appendix 3. An assessment of technical quality is also carried out.

In addition to the 10% audit, the service will be responsible for providing for KPIs on the following:

- Clinical cancellations

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- Clinical performance reports
 - Incomplete examinations
 - Rejections
 - Reasons for clinical cancellations
 - Uncompleted reports
 - Workflow
 - Clinical audit summary
 - Acute patients transferred
 - Major reporting errors
 - Patient safety incidents
 - Serious untoward incidents
 - Complaints
 - Patient and referrer satisfaction
 - Inbound queries from referrers at PRC
 - Inbound queries on patient programme leaflets at PRC

MRI, DEXA and X-ray

MRI and DEXA scans and plain X ray films are carried out in a number of static and mobile sites. The majority of the mobile and static sites will be run by the diagnostic and imaging section of InHealth, but there will also be a number of BMI hospitals where the MRI scanners and X-ray departments will be used to provide services for the scheme. In the case of BMI hospitals, the reports will, as with the InHealth services, all be sent to the reporting house for radiologist reporting.

The same MRI, X ray and DEXA protocols are used for all patients, reviewed regularly by the appropriate radiologists, Superintendent radiographers and members of the Independent Advisory Board. Audits are carried out to include compliance with the agreed protocols.

Radiography

Recruitment and competency assessment

All radiographers involved in the scheme have been recruited in accordance with the guidelines provided for the recruitment of radiographers within the NHS. Overseas radiographers have been fully competency assessed and will be working in conjunction with an experienced UK radiographer for the first month of the contract.

Radiographers working for the BMI Group, carrying out MRI, DEXA X-ray or ultrasound will under the overall supervision of Katie Taylor, the imaging lead for the General Healthcare Group. In each BMI hospital the radiographer will have the support and supervision of the radiologist lead for that hospital. These radiologists have been identified and will be clinically responsible for the radiography service.

Within the InHealth Group professional liaison with radiographers will be the responsibility for of the London Superintendent Radiographers for MRI and X-ray who will provide guidance and support on audit, clinical governance and continuing professional development.

Audit and Governance

All radiographers involved in this scheme will meet with their clinical manager regularly to review their activity and revise, if necessary, any protocols and procedures.

The reporting house have a system for informing the radiographers of any enduring problems with the quality of the images produced. Radiographers will ensure that the reporting house is aware of any problems encountered during imaging which might compromise the quality of the image. The radiographer will, on discussion with the radiologist, decide whether or not the patient examination should be re-scheduled or whether or not the patient is unsuitable for examination. In both cases, the GP would have been informed that there is either to be a second examination performed or the patient is referred back to them as unsuitable for the examination and alternative diagnostic tests may be recommended.

InHealth MRI radiographers are subject to a 10% independent radiographic quality audit carried out by an external company - IAS. Results are produced for the superintendent MRI radiographer and for each MRI radiographer.

X ray and DEXA audit is carried out by and shared with radiographers by the Superintendent (X-ray and DEXA).

Daily Quality Control is carried out on all MRI, X-rays and DEXA scanners.

The clinical lead for radiography within BMI and within InHealth will be members of the corporate clinical governance group and will be responsible for the overview and quality assurance of the radiography service within their organisation.

Radiology

Recruitment and competency assessment

The reporting of MRI and plain film is carried out by a reporting house. Radiologists employed by the reporting house are all doctors who are on the GMC specialist register for radiology and have completed their most recent cycle of continuing professional development. All radiologists have the following experience documented over the previous 12 months (as relevant to their reporting workload)

Neuro radiology MRI – 250
Head and neck MRI -150
Musculoskeletal MRI – 500
Cardiac MRI – 50
Chest MRI – 150
Vascular MRI – 200
Abdomen and pelvis MRI – 350

Breast MRI – 50
X-Ray – 2000
Ultrasound -500
CT – 250

And have a significant reporting error rate or less than 0.1% and have up to date accreditation with the Royal College of Radiologists CPD scheme or equivalent.

Audit and Governance

The reporting house has its own robust clinical audit processes which includes a 10% independent audit and also a continuing review of the relevant KPIs. The KPIs for diagnostic imaging include a clinical audit summary by modality using the reporting clinician's activity outputs and GMC classification of reporting discrepancy grades of 1 – 5. the action required as a result of a category 3, 2 or 1 score is described in appendix 3

Also, there is an IDPI related to failure to conduct weekly diagnostic error double-reporting audit. The reporting house will be responsible to the Clinical Director of InHealth Netcare for providing the results of this weekly audit.

Other relevant KPI are:

- Clinical cancellations
- Clinical performance reports
- Incomplete examinations
- Rejections
- Reasons for clinical cancellations
- Uncompleted reports
- Workflow
- Clinical audit summary
- Acute patients transferred
- Major reporting errors
- Patient safety incidents
- Serious untoward incidents
- Complaints
- Patient and referrer satisfaction
- Inbound queries from referrers at PRC
- Inbound queries on patient programme leaflets at PRC

At all times a radiologist will be also available to provide support and advice to the radiographers.

Reports will be produced in accordance with the guidance of the Royal College of Radiologists Standards for Reporting and Interpretation of Imaging Investigations - 2006

Radiologists and radiographers in the reporting house will refer back to radiographers any examinations which they feel are not of adequate technical quality for them to be able to report them. This will, if possible, be done by

discussion with a radiographer and a joint decision made as to whether or not the investigation should be re-scheduled or the patient GP informed that the patient is unsuitable for investigation. Category 1 or 2 errors and clinical Incidents will be reported immediately to the Quality and risk manager.

Ultrasound

Recruitment and competency assessment

Ultrasound is provided in a number of community based settings as well as within some BMI hospitals.

Services provided by BMI hospitals will be delivered in accordance with the previous sections and accountability for the ultrasonographers will rest with the head of imaging for the General Healthcare Group. Access to specialist advice and support for these ultrasonographers will be within the BMI system using consultant radiologists who have practising privileges at the relevant BMI hospitals. Radiologists carrying out Ultrasound scans are also responsible for reporting. they have to have carried out a minimum of 500 relevant scans in the previous 12 months and demonstrate an error rate of less than 0.1%.

All ultrasonographers joining the service are assessed using the competency assessment framework and in addition will be working in supervised practise for their first 50 - 100 scans and only deemed to be able to practice independently, unsupervised and within a community setting with only a healthcare assistant for support, when the assessor has signed them off.

The role of the assessor will be to assess their ability to carry out the scan, to interpret the results, to prepare the report and most importantly to assess whether or not the test and its results are within their demonstrated competence. Their knowledge and confidence in reporting and their understanding of when to refer for a specialist opinion will be considered in the assessment of their supervised practise. During the supervised practise the assessor will convene a regular meeting to review cases and particularly to review interesting cases and complex referrals.

Audit and governance

Audit of ultrasound is of itself challenging in that the gold standard audit can only be carried out where two practitioners are prepared to carry out ultrasound on the same patient at the same time. For this reason, our audit programme comprises the following:

- I. During the initial assessment process the ultrasonographer will work with a radiologist/assessor until 50 scans have been reviewed. If the assessment is satisfactory the sonographer will be signed off, if not a further 50 scans will be supervised.
- II. For independent audit, there will be a sample of each practitioner's

activity, from the images that are stored on the PAC system that will be made available to an independent auditor who will review the images and the reports and make comparison to the report provided by the ultrasonographer. The results of the 10% audit will be signed off by the relevant members of the independent advisory board. The results of the audit will be will be made available to the radiologists, radiographers and sonographers working within the community based ultrasound service.

- III. Interesting cases will regularly be presented at internal peer review meetings where other ultrasonographers and radiologists will be able to comment on the findings ,the execution of the test and the subsequent report
- IV. Periodically every ultrasonographer will carry out a clinic with a colleague and each test will be reviewed contemporaneously by a colleague - either a fellow ultrasonographer or a radiologist.
- V. All the images for ultrasonography will be stored and available for subsequent review by the General Practitioner or the hospital department to which a patient has been referred. This will in itself act as peer review of the reports provided by the ultrasonographer.
- VI. Ultrasonographers will review their own work, both by sharing with their colleagues within the scheme, but also by contacting GPs to find out the what GP management and subsequent intervention was carried out as a result of the ultrasound scan report. Ultrasonographers will be encouraged to contact GPs to follow up cases.
- VII. A radiologist-led specialist referral clinic will be held at least weekly to which complex and difficult cases will be referred by the ultrasonographer. The clinic will be attended by an ultrasonographer and findings fed back to the originating ultrasonographer.

Other relevant KPIs are:

- Clinical cancellations
- Clinical performance reports
- Incomplete examinations
- Rejections
- Reasons for clinical cancellations
- Uncompleted reports
- Workflow
- Clinical audit summary
- Acute patients transferred
- Major reporting errors
- Patient safety incidents
- Serious untoward incidents
- Complaints
- Patient and referrer satisfaction
- Inbound queries from referrers at PRC
- Inbound queries on patient programme leaflets at PRC

Referral Protocols, Pathways and Quality Assurance

All ultrasound equipment will be monitored and calibrated in accordance with the guidance from the Royal College of Radiologists.

(Ref: Royal College of Radiologists Standards for Ultrasound Equipment 2005.

Services will be delivered in accordance with the guidance from the British Medical Ultrasound Society - September 2003 - Extending the provision of ultrasound services in the UK

Reports will be produced in accordance with the guidance of the Royal College of Radiologists Standards for Reporting and Interpretation of Imaging Investigations - 2006

The ultrasound team have developed their own protocols for ultrasound and an agreed pathway for all the reporting and follow up of ultrasound results. We are not aware of any published guidelines or protocols for the delivery of ultrasound examination, therefore we will expect our ultrasonographers to liaise with the local NHS to ensure their protocols are where possible, be in line with local NHS Trust protocols.

The clinical lead, Barbara Mushambadope, will be responsible for convening regular audit and governance meetings, which will also be used for post-graduate education and continuing professional development. They will also be a member of the corporate clinical governance meeting and present results and audit to that meeting.

Our independent advisory board has a number of experts on ultrasonography. These include Ms Salma Hasnain, Lead Superintendent Sonographer from Guys and St Thomas' Hospital and a member of the British Medical Ultrasound Society, Dr Robin Wilson, a radiologist at Kings College Hospital and past president of the International Breast Ultrasound School.

Physiological measurement

Recruitment and competency assessment

ATOs will carry out physiological measurement – ECG, 24 hour BP and ECG monitoring, in a number of community and hospital settings. They have all been assessed using a competency framework and deemed to be competent to carry out physiological measurement unsupervised, on the basis of their previous experience and their assessed competency. All reports for 24 hour ECGs and BPs will be validated by a cardiac physiologist.

ATOs access to a cardiologist for advice. In the event of an emergency they will activate the Emergency (999 referral) protocol. In the event of a serious clinical condition being diagnosed they will seek advice and flag the report as urgent.

Audit and Governance

A 10% sample of the traces and reports are reviewed by a consultant cardiologist and reported to team peer review meetings. ATOs will be encouraged to contact GPs to confirm the outcome of their report in terms of medical management and referral to a cardiologist. The Operations director will be responsible for on going training and development of the technical team. In addition the ATOs will be able to attend joint audit meetings with the echocardiographers.

Relevant KPIs are:

- Clinical cancellations
- Clinical performance reports
- Incomplete examinations
- Rejections
- Reasons for clinical cancellations
- Uncompleted reports
- Workflow
- Acute patients transferred
- Patient safety incidents
- Serious untoward incidents
- Complaints
- Patient and referrer satisfaction
- Inbound queries from referrers at PRC
- Inbound queries on patient programme leaflets at PRC

The independent clinical advisory board includes NHS experts in Cardiology and Physiological measurement. This includes a consultant cardiologist and the manager of cardiac physiology at John Radcliffe Oxford, Dr Keith Johnson.

Audiology

Audiologists will be assessed using an agreed competency assessment framework.

Each team will have a senior and junior audiologist.

The group will have a clinical meeting each month to discuss audit results, interesting cases and review clinical and operational policies and procedures

The 10% audit will be carried out weekly and reported to the clinical governance committee.



INHEALTH NETCARE

LONDON DIAGNOSTICS SCHEME

**STRATEGIC FRAMEWORK FOR CLINICAL GOVERNANCE – REVISED
VERSION**

Name:

Position:

I have received and read the Strategic Framework for Clinical Governance.

Signed:

Dated: 08.05.08

Return to:
Dr Sarah Wilson

Sarah.wilson@inhealthgroup.com

APPENDIX 1

The Clinical Governance committee

Clinical Director – Dr Sarah Wilson
Clinical operations Director – Michael Bell
Quality and risk manager – Jan Hanson
Imaging – Radiology – Dr Sanjiv Agarwal (CEO – 4 Ways)
Imaging (including ultrasound) BMI – Katie Taylor
Echocardiography – TBA
Endoscopy – Gary McHardy
Ultrasound – Barbara Mushambadope
Audiology – Tony Hammond
Clinical Audit and MRI – Gill Winter
X ray and DEXA lead – Elaine Hamnett
Triage team – Alexandra Lipton

For information and if required:

Imaging (InHealth Diagnostics) - Wendy Wilkinson
Audit – 4 Ways – Derek Taylor
PRC – Belinda Dhami
PACS manager – Sarah Moorhead
IT Director – Andrew Heggs
Paul Embley - COO

APPENDIX 2

LONDON DIAGNOSTICS INDEPENDENT ADVISORY BOARD

From InHealth Netcare – London Diagnostics Scheme

Clinical Director – Dr Sarah Wilson

Clinical services manager – Mike Bell

Specialist Advisors *

Mr Ian Swift – consultant Surgeon (endoscopy) Mayday Hospital

Dr Robin Wilson – consultant radiologist - Kings College Hospital and Guys and St Thomas' Hospital

Ms Salma Hasnain – Senior Superintendent Sonographer – Guys and St Thomas' Hospital

Mr Gerwyn Ramsay – Radiographer and retired clinical director – lead on radiography training (resigned 1.11.07).

Dr David Sarma – Consultant Radiologist – (MRI) Mayday hospital

Dr Keith Johnson – Cardiac Physiology Clinical Unit Manager – The John Radcliffe Hospital

Dr Paul Turner – Vice Chairman of the British Society of Audiology Training Committee

Dr Claire Stephens, Dr Hina Ansari, Dr Gareth Childlow and Dr Phil Green –GPs from London and East Midlands

**These advisors are all full time NHS clinicians*

Appendix 3

AUDIT OF REPORTS AND IMAGES – INHEALTH PROCEDURE FOR WAVE 2

CATEGORY 5	No Disagreement
CATEGORY 4	Disagreement over Style &/or presentation of the report including failure to describe clinically insignificant features.
CATEGORY 3	Clinical significance of disagreement is debatable or likelihood of harm is low
CATEGORY 2	Definite omission or interpretation of finding with strong likelihood of moderate morbidity but not threat to life
CATEGORY 1	Definite Omission or misinterpretation with unequivocal potential for serious morbidity or threat to life

Auditors will categorise reports according to the criteria above.

Category 5 – no action required

Category 4 – Routine feed back to reporter with any comments from auditor

Category 3 – Auditor and reporter discuss all the reports and agree if an amendment and/ or immediate action required. If disagreement between them a third opinion is sought and their decision actioned. Amended reports will be sent out to referrer immediately. The auditor will decide if it is necessary to telephone GP or referrer to discuss the case. Record will be made of any discussions with the referrer.

Category 2 – Auditor will arrange for amended report to be completed immediately. Report will be faxed or emailed to referrer immediately. This will be followed up by phone call to discuss with referrer the action required. A record will be kept of the discussion and outcome.

The reporter will continue to work in a supervised capacity ie all reports double reported before issuing report or working supervised in the clinic or reporting house. A 100% independent audit of the previous 3 months work will be carried out. Independent working will be reinstated following satisfactory results of the 100% audit, double reporting and supervision.

Satisfactory = less than 10% category 3 and no category 1 or 2.)

Category 1 - Auditor will arrange for amended report to be completed immediately. Report will be faxed or emailed to referrer immediately. This will be followed up by phone call to discuss with referrer the action required. A record will be kept of the discussion and outcome.

Reporter will be suspended from clinical work/reporting.

