State Hospitals Board for Scotland

Local Report ~ March 2010

Clinical Governance & Risk Management: Achieving safe, effective, patient-focused care and services
Clinical Governance & Risk Management: Achieving safe, effective, patient-focused care and services
NHS Quality Improvement Scotland (NHS QIS) is committed to equality and diversity. We have assessed the performance assessment function for likely impact on the six equality groups defined by age, disability, gender, race, religion/belief and sexual orientation. For this equality and diversity impact assessment, please see our website (www.nhshealthquality.org). The full report in electronic or paper form is available on request from the NHS QIS Equality and Diversity Officer.

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1 Setting the scene

This report presents the findings from the clinical governance and risk management (CGRM) peer review to the State Hospitals Board for Scotland. This review visit took place on 10 December 2009, and details of the visit, including membership of the review team, can be found in Appendix 3.

The State Hospitals Board for Scotland is a special NHS board and legally became part of the NHS in Scotland on 1 April 1995. Situated in rural Lanarkshire, midway between Glasgow and Edinburgh, the NHS board provides inpatient psychiatric care in conditions of special security for patients from Scotland and Northern Ireland.

Referrals to the State Hospitals Board for Scotland come from other NHS hospitals, the courts and prisons. Patients, whether referred via the NHS or the criminal justice system, are generally transferred back to local NHS services when they no longer require the security of the State Hospitals Board for Scotland. The NHS board aims to ensure public safety by providing care and treatment of the highest standards, and it is accountable for the clinical services it provides, through the framework of clinical governance.

Further information about the local NHS system can be accessed via the website of the State Hospitals Board for Scotland (www.tsh.scot.nhs.uk).

Background

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 and leads the use of knowledge to promote improvement in the quality of healthcare for the people of Scotland and performs three key functions: providing advice and guidance on effective clinical practice, including setting standards; driving and supporting implementation of improvements in quality; and assessing the performance of the NHS, reporting and publishing the findings. In addition, it also has central responsibility for patient safety and clinical governance across NHSScotland.

The National Standards for Clinical Governance & Risk Management: Achieving Safe, Effective, Patient-focused Care and Services were published in October 2005. These standards are being used to assess the quality of services provided by NHSScotland.

The national standards for clinical governance and risk management were first reviewed during 2006–2007. Peer review visits to all NHS boards in Scotland were conducted between May 2006 and May 2007 to assess performance against the standards. Local reports for each NHS board were published during the review cycle and a national overview of the key findings and recommendations was published in October 2007. NHS QIS has subsequently agreed with the Scottish Government that it will review the national standards for clinical governance and risk management at a strategic level, in each NHS board, every 3 years.

Review process

The review process has three key phases: preparation prior to the performance assessment review, the review visit, and report production and publication following the visit. (See flow chart in Appendix 2 for further detail.)

A quality improvement tool is used by each review team to assess performance against the standards. The quality improvement tool enables the review team to assess how an NHS board is achieving each standard through the cycle of development, implementation,
monitoring and reviewing. These four key stages represent the continuous improvement cycle through which each NHS board can ensure that all patients receive safe, effective, patient-focused care and services.

The most appropriate performance assessment statement is agreed by the review team to describe an NHS board’s current position against each core area. This allows an overall performance assessment statement to be arrived at for each of the standards, which indicates the NHS board’s level of achievement for each standard.

The agreed overall performance assessment statement for each standard will be added together for each NHS board and this information will feed into the NHSScotland health, efficiency, access and treatment (HEAT) targets, set by Ministers, in June 2010.

Each review team is led by an experienced reviewer, who is responsible for guiding the team and ensuring that team members are in agreement about the assessment reached.

**Links with other organisations**

Clinical governance and risk management is part of a shared agenda. During this review process, we have focused on working more effectively in partnership with the following organisations that monitor other aspects of healthcare in order to inform the assessment process:

- Audit Scotland
- Chief Scientist Office
- NHS Education for Scotland
- NHS National Services Scotland
- Scottish Government Health Directorates, and
- Scottish Health Council.

We have agreed that the following areas will not be reviewed by NHS QIS as they are already being reviewed as follows:

- **Criterion 1c.5:** Scottish Health Council (patient focus and public involvement assessment)
- **Criterion 3a.2:** Scottish Health Council (patient focus and public involvement assessment)
- **Criterion 3a.5:** Chief Scientist Office (research governance assessment)
- **Core area 3e:** NHS National Services Scotland (information governance assessment)

We have also agreed an operational protocol with Audit Scotland which sets out broad principles for collaborative working, primarily between NHS QIS and Audit Scotland, covering issues such as the sharing of information, communication and liaison, and avoiding the duplication of work which relates specifically to Audit Scotland’s national reporting.
2 Summary of findings

A summary of the findings, including strengths and recommendations, from the review is illustrated in this section. Overall performance is rated using the four assessment categories. The most appropriate category is agreed by the review team to describe the NHS board’s current position against each core area – indicated by the shaded areas below. A detailed description of performance against the standards is included in Section 3.

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Strengths

The NHS board has:

- comprehensive risk management systems in place, which are well embedded from ward to Board.
- demonstrated a proactive approach to the development of the new hospital.
- robustly implemented the care programme approach and is continually reviewing its use within the hospital.
- demonstrated that it is a listening organisation, through both its internal and external communication arrangements.

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- been awarded the Investing in Volunteers quality mark for work with public volunteers in the hospital.
- a unique approach to equality and diversity, with a focus on human rights.
- strong performance management systems in place, with clear lines of reporting.

**Recommendations**

**The NHS board to:**

- continue to evaluate its committee structures, to ensure that there is no overlap between committees and teams.
- consolidate evaluation activity already under way for emergency and business continuity planning.
- develop an evaluation plan for equality and diversity arrangements.
- continue with the work already under way to review and update outstanding policies.
- develop a specific training plan for risk across the organisation.
3 Detailed findings against the standards

Standard 1: Safe and effective care and services

Standard statement
Care and services are safe, effective, and evidence-based.

Overall performance assessment statement:
The NHS board is monitoring the effectiveness of its arrangements to control risk, continually monitor care and services and work in partnership with staff, patients and members of the public.

Core area: 1(a) Risk management

Performance assessment statement: The NHS board is monitoring the effectiveness of its risk management arrangements across the organisation.

A risk management strategy is in place for the period 2009–2012. The high level implementation plan included within the strategy lists key strategic aims, such as the proactive identification of risk, the activities which will contribute to the achievement of these aims and timescales for implementation or review.

Governance arrangements for the management of risk are outlined within the strategy. The audit committee oversees risk management arrangements, while both the staff governance and clinical governance committees oversee people management and clinical risks respectively. The Board is assured of the implementation of arrangements through these three committees. The hospital management team (HMT) is responsible for the operational management of risk. The senior management team (SMT) meets quarterly as the risk and governance committee to look at overarching strategic issues and review the way risk is being managed. The risk and governance committee then reports to the audit committee. The finance and performance director is the executive lead for risk management and plays an important co-ordination role in risk management work.

The strategy indicates that the State Hospitals Board for Scotland sees risk as a responsibility for staff at all levels of the organisation and seeks everyone’s input to minimise risk. Mechanisms are in place to allow members of staff to highlight any suggestions or issues concerning the risk management structure or risk reporting system. It was reported that they can raise this with the risk management team or the HMT, via the committees which feed into these teams.

A number of risk registers are in place at different levels within the NHS board. These include a corporate risk register, a register for the redevelopment of the hospital and local or departmental registers. The corporate risk register brings together service/directorate risks and strategic/corporate risks. It is monitored by the risk and governance committee and other relevant Board committees. It was reported that the risk and governance committee updates the HMT on the corporate risk register, thus ensuring that corporate risks are fed down to the operational level. Within the corporate risk register, information on progress over time for specific risks is easily accessed, and initial, current and target risk scores are tracked. Risk management is linked with wider organisational objectives through
this register, as each risk is linked to a section within the local delivery plan. Risk register guidance provides an overview of the risk register process and a helpful checklist for identifying, assessing, controlling and reviewing risks. A generic risk assessment form is contained within this guidance.

Robust incident reporting mechanisms are in place within the NHS board. At departmental level, all adverse events are recorded electronically via Datix and it was reported that all staff have access to the Datix incident reporting module. All incidents are reviewed, with the level of review dependant on the risk score allocated to them. The incident reporting and review policy outlines the processes for reporting and assessing incidents, and states which types of incidents will result in a critical incident review. Guidelines for undertaking an investigation are included within this policy. In addition, an investigation process timeline indicates timescales for the completion of each stage of the investigation and further monitoring. It was reported that each ward/department has a health and safety control book which aids staff in identifying and assessing risks, and evidence demonstrated that the control books have been subject to audit.

Incident information is disseminated widely throughout the NHS board. Incident information and analysis is reported by the risk management team to the risk and governance committee, the health and safety committee, the HMT, and the clinical and staff governance committees. It was reported that information is also communicated to clinical teams via reports. The NHS board reported that the information on incidents throughout the organisation is shared through the HMT. The NHS board reported that an incident reporting survey had been carried out and that it was planning to repeat this survey.

Risk management training forms part of the induction process for new staff and is included within health and safety training. Furthermore, complaints and Datix training is included within the corporate and directorate training plan. While commending arrangements in place, the review team encouraged the NHS board to develop a specific training plan for risk across the organisation.

Since the last NHS QIS peer review visit, the NHS board has continued to evaluate the effectiveness of its risk management arrangements. A planned and co-ordinated approach to this evaluation is demonstrated by the clinical effectiveness and risk management evaluation plan (2009–2012) and fed back by the risk management annual report. A specific evaluation and review plan for risk management lists how the different components of the system will be evaluated, for example the corporate risk register will be evaluated through annual review and a consultation event. The NHS board reported that, although the plan is dated 2009, an evaluation framework had previously been in place. Through the process of updating this framework, the need to repeat the cultural survey was recognised. The review team encouraged the NHS board to further evaluate structures and processes, which would place the NHS board in a good position to move towards the level where it is reviewing and continuously improving its risk management arrangements across the organisation.
Core area: 1(b) Emergency and continuity planning

Performance assessment statement: The NHS board is monitoring its emergency and continuity planning arrangements across the organisation.

An approach to emergency and business continuity planning which reflects the specific characteristics of the State Hospitals Board for Scotland has been implemented and monitoring of arrangements undertaken. As the NHS board is not a category 1 responder, responsibilities are not the same as in a territorial NHS board.

A range of emergency and business continuity plans are in place covering the three levels of planning, ranging from minor service disruption to major incidents where activity is seriously disrupted. Level 2 plans (where significant service disruption occurs) are monitored by the business continuity planning group. The NHS board contingency planning liaison group, which includes representatives from a number of external bodies including the police, fire and ambulance services, monitors the Level 3 continuity plans and the incident command manual. The review team noted that a full review of Level 3 continuity plans took place in April 2005, with further revisions of detail taking place both as and when required, and on an annual basis.

The security director is the lead for business continuity planning. This lead is supported by the business continuity planning group, which oversees the development, implementation and monitoring of business continuity plans and reports to the risk and governance committee on a regular basis. The contingency planning liaison group oversees arrangements in the event of a major incident, and also the hospital’s corporate contingency plan. This group reports to the Lanarkshire local area group, which is part of the Strathclyde emergencies co-ordination group. Updates on the work of the contingency planning liaison group are provided twice a year to the business continuity planning group. The NHS board reported that the business continuity planning group reports to the risk and governance committee via an annual report. In addition, an annual report on business continuity planning is provided to the audit committee. The risk management annual report contains an overview of progress.

Evidence demonstrated that the NHS board has integrated its emergency planning and business continuity arrangements with those of partner organisations. A memorandum of understanding is in place between the NHS board and Strathclyde Police which sets out the roles of each organisation in the event of a serious incident. In addition, it was reported that multi-agency exercises are held every 3 years involving a number of partner organisations such as the police, fire and ambulance services.

Training arrangements are in place to ensure that staff are prepared in the event of an emergency or should an incident occur which may affect the ability of the NHS board to continue to operate. The business continuity training plan details the types of training in place for both emergency and business continuity planning. Progress is reported within this training plan, for example whether the target group has been fully trained.

The NHS board has considered local communities within its emergency arrangements. Local sirens are in place in surrounding villages to alert the local community should a patient go missing. A leaflet has been produced to inform residents of the different sounds of the siren, what to do should it sound and how they will be kept updated of the situation.

Evidence submitted has demonstrated that a formal schedule of review has commenced for all emergency and business continuity plans in the NHS board in 2009–2010, which includes annual real-world testing and exercises on a rolling basis. The results of these are
reported to the business continuity planning group, alongside recommendations for improvement. The critical incident review annual report 2008–2009 demonstrates that the effectiveness of the incident reporting and review policy and procedure were also evaluated in September 2008, and approved by the HMT. This details the process for identifying priority recommendations, critical incident review action planning, and processes to inform the chief executive and general managers. The NHS board further reported that the function, role and membership of the business continuity planning group has been evaluated and the business continuity planning training plan has also been updated following an evaluation of existing training.

The review team also commended the proactive approach to emergency and business continuity planning displayed by the review and update of plans in preparation for the redevelopment of the hospital.

At the time of the peer review visit, the NHS board demonstrated that monitoring of business continuity and emergency planning arrangements was taking place, however the review team would further recommend the introduction of a systematic, documented approach of ongoing review and continuous improvement.

Core area: 1(c) Clinical effectiveness and quality improvement

Performance assessment statement: The NHS board is monitoring the effectiveness of its arrangements for clinical effectiveness and quality improvement across the organisation.

A clinical effectiveness strategy and delivery plan is in place for the period 2008–2010. Roles and responsibilities are outlined alongside key clinical effectiveness objectives, which include the aim to embed the principles of clinical effectiveness and quality improvement, to enable improvements in care. The clinical effectiveness programme of work is also included and evidence demonstrated that progress is monitored and reported. A number of supporting strategies are in place including the integrated care pathway (ICP) strategy (2007–2010), the nursing practice development strategy (2006–2009) and the patient safety strategy (2009–2011).

The medical director is accountable to the Board for clinical effectiveness and each clinical director oversees clinical activity within their area of responsibility. At the operational level, the general manager works to ensure that the aspects of the strategy and delivery plan are implemented. It was reported that the physical health steering group, mental health practice steering group and the medicines committee are responsible for aspects of clinical effectiveness, and report to the clinical governance committee.

The clinical effectiveness team aims to ensure that the objectives of the strategy are delivered and it does this through a number of continuous improvement methods. Much clinical effectiveness work is carried out by multidisciplinary teams and professions within the NHS board. The clinical effectiveness team supports these groups and has oversight of all clinical effectiveness work within the NHS board.

Clinical effectiveness work within the NHS board focuses around three key areas: clinical audit, national guidelines and standards, and ICPs. The NHS board reported that induction training provides an overview of these three key areas. A 2-day workshop on clinical audit was delivered in 2009, focusing on how to design a clinical audit and make improvements.
in practice. A range of training related to clinical effectiveness is listed in the corporate and directorate training plan, for example an annual refresher session for ICP link nurses.

Evidence demonstrated that the NHS board carries out a broad range of clinical audit across the organisation. Furthermore, evidence demonstrated that audits are followed up. An audit of multiple prescribing of antipsychotics in 2007 was followed by a further audit in 2009. An audit plan lists a number of completed audits relating to clinical effectiveness and others planned for the future. A clinical audit database is in place and it was reported that this collates information on who is undertaking audit projects. In addition, the review team was informed that staff are encouraged to carry out audit work, for example supervision arrangements support junior doctors undertaking audits.

Evidence demonstrated that the NHS board is monitoring its arrangements for clinical effectiveness. A clinical effectiveness and risk management evaluation plan is in place for the period 2009–2012, and outlines how progress against specific criteria will be monitored.

In relation to national guidelines and standards, the membership and meeting frequency of the clinical standards group has been evaluated. It was reported that changes were made to its membership as a result of this evaluation. Evidence also demonstrated that consideration of the group’s remit had taken place. In addition, the need was recognised for a system to measure current compliance against standards and guidelines unmet when previously assessed. A new system has been developed for re-evaluating guidelines to ensure that actions put in place have been successful. This new system is at the end of its initial pilot phase. The review team commended the work of the clinical standards group within the NHS board.

Further monitoring was evidenced by the evaluation of ICP systems and processes, which took place in 2006–2007. This was carried out to determine whether any gaps in processes existed and following the recognition of the need to update documentation relating to ICPs. Evidence demonstrated the consideration of ICP reporting structures at this time. Further monitoring was carried out in 2009 when a review of ICP documentation was carried out. In addition, a new variance analysis tool was piloted, which aimed to streamline reporting. Arrangements for ICP update reporting have also been considered, including the feedback mechanisms and plans are in place to review the way that interventions are reported.
Standard 2: The health, wellbeing and care experience

Standard statement
Care and services are provided in partnership with patients, carers and the public, treating them with dignity and respect at all times, and taking into account individual needs, preferences and choices.

Overall performance assessment statement:
The NHS board is reviewing and continuously improving its arrangements to provide care and services that take into account individual needs, preferences and choices.

Core area: 2(a) Access, referral, treatment and discharge

Performance assessment statement: The NHS board is reviewing and continuously improving its arrangements with a partnership approach to access, referral, treatment and discharge across the organisation.

The NHS board has a range of methods to provide information on services to patients, carers and the public. At the time of the NHS QIS review visit, it was reported that there is representation from each ward area at the patient partnership group and that community meetings take place in wards. Furthermore, through the feedback system ‘Compliments, Comments, Concerns and Complaints’ (the 4 Cs), posters are placed in each ward detailing feedback given. An interpreter and translation policy is in place to support those whose first language is not English, or who have other communication difficulties such as hearing loss. The NHS board reported that a number of key themes have arisen from patient feedback, such as privacy, environment and time on the telephone, and that it is working towards improving areas of concern, where it is possible to do so.

The clinical systems management group oversees much of the work relating to access, referral, treatment and discharge. This group feeds into the clinical directors group, which then reports to the risk and governance committee. The clinical governance committee is responsible for the overall arrangements relating to access, referral, treatment and discharge.

A patient focus and public involvement carer policy outlines the NHS board’s commitment to supporting carers and ensures that they remain involved in the lives of their relative or friend. A hospital-based carers reference group allows carers to become involved in the decision-making process, and there is carer representation on the patient focus public involvement steering group. A number of events were held during national carers’ week 2008, for example tours of the activity and recreational centres, and musical entertainment.

The care programme approach (CPA) is robustly implemented throughout the NHS board. In line with Scottish Government policy, all patients in the care of the NHS board are now subject to CPA. Within the NHS board, CPA was originally applied to transfer and treatment planning only. However, its application has been broadened and now includes the whole patient pathway. CPA guidance is available to staff and it was reported that an online training module on the treatment planning process can also be accessed. A treatment plan audit was carried out in April 2009 to check whether staff were completing a number of core documents within the CPA process. A strong commitment to involving
patients and their named person in the planning of their treatment was evident. The review team commended the use of CPA and encouraged the NHS board to maintain its systematic approach to discharge planning.

Evidence demonstrated a planned approach to the evaluation of the effectiveness of arrangements across this core area. The NHS board is evaluating the way it provides information to patients. A patient information audit was carried out in January 2008 to determine the accessibility of information across the wards. A number of recommendations were made, such as the need for a central information resource within wards. The NHS board reported that information stations were put in place as result of this audit; particularly in relation to information regarding psychological therapies, the patient activity and recreation service, and the health centre. In the 2009 patient survey, 70% of patients reported that they were able to access information they need on the ward easily. It was reported that information stations have been set up around the hospital providing information for patients on the services that are available to them.

The NHS board is reviewing and continually improving its use of CPA and it was reported that reviews are carried out annually. A review was carried out in September 2006 and a list of recommendations was developed, including implementing a staff development programme. Evidence demonstrated the consideration of the supporting arrangements for CPA. A full-time CPA manager was to deliver these recommendations and a CPA administrator has been appointed. Progress against this list was assessed during a review which was completed in August 2008. Recommendations were based on three factors: learning from the previous review, analysis of statistics and feedback from users. In addition, the remit of the CPA steering groups has been developed.

### Core area: 2(b) Equality and diversity

**Performance assessment statement:** The NHS board is monitoring the effectiveness of its arrangements for equality and diversity across the organisation.

The State Hospitals Board for Scotland has continued to build on monitoring activity demonstrated in the last NHS QIS peer review visit. The review team commended the NHS board’s unique approach to equality and diversity, with an additional focus on human rights, which it considers its seventh strand of the Fair for All agenda.

A single equality scheme is in place for the period 2007–2010 and addresses all six strands of the Fair for All agenda. A number of policies are in place to support equality, diversity and human rights arrangements within the NHS board. The spiritual and pastoral care policy (for the period 2007–2010) outlines arrangements, including the responsibilities of the spiritual and pastoral care team. The commitment made by the NHS board is also clearly explained, for example a spiritual assessment is carried out as part of the overall assessment of each patient. An equality and diversity action plan is in place for the period 2007–2010. It sets out six key aims and includes a range of actions addressing each of the six strands of the Fair for All agenda.

The equality, diversity and rights group is chaired by the nurse director who is also the lead director for patient focus and public involvement, and equality and diversity. Support is also provided by the patient focus and public involvement co-ordinator and, in addition, each of the six strands has a designated lead. The equality, diversity and rights group
reports to the HMT and the clinical governance committee, via the patient focus public involvement steering group.

The review team commended arrangements in place to involve patients and listen to their views. The review team was informed that, as a result of a decision made by the patient partnership group, football colours are no longer worn within the State Hospital.

The review team was informed that policies are not approved unless they have been equality and diversity impact assessed. The NHS board reported that approximately 15 members of staff are trained to carry out equality and diversity impact assessments. An equality and diversity rapid impact assessment tool is available, and contains a number of key questions relating to, for example, which groups will be affected by the policy/proposal. It was reported that work on equality and diversity impact assessment of services is currently under way.

Evaluation of evidence has been used to shape development of the new hospital, which is currently under construction. The NHS board reported that the new multi-faith centre and also the advocacy drop-in centre were put in place following evaluation activity. Following feedback from patients, a new patient telephone system was piloted and later evaluated; the revised patient telephone system is now in place.

The NHS board is monitoring arrangements for equality, diversity and human rights in a number of ways. The NHS board took part in national benchmarking exercises run by NHS Health Scotland and it was reported that work has been carried out to address gaps highlighted. In addition, an equality, diversity and rights audit was carried out in January 2008. One hundred and twenty staff completed questionnaires which contained questions relating to, for example, the accessibility of equality and diversity information. A number of recommendations arose from this audit, including the need for an induction training programme. The review team was informed that all new employees now receive an equality, diversity and human rights training session, and that refresher sessions are provided for existing staff in the form of a 1-day training programme. Furthermore, it was also reported that training days have taken place for members of the Board. The review team encouraged the NHS board to develop a plan that would co-ordinate evaluation activity, and enable the NHS board to test delivery and demonstrate improvement in its equality and diversity arrangements.

**Core area: 2(c) Communication**

**Performance assessment statement: The NHS board is reviewing and continuously improving its arrangements for internal, staff and patient communications across the organisation.**

Communication arrangements within the NHS board are detailed within its communications framework and communications action plan. This is an overarching document that is intended to provide an integrated approach to effective communication within the NHS board and its stakeholders. This is further underpinned by an internal communications strategy (2007–2010), new hospital communications strategy (2006–2010) relating to current service developments, and external communications strategy (2008–2010).

At the time of the 2006 NHS QIS peer review visit, it was noted that the NHS board had developed robust communication systems and was successfully monitoring its policies,
strategies and procedures for improving the ways in which staff and patients engage with each other and across the organisation. Since then, the NHS board has invested significant resources to continuously improve arrangements for both internal and external communication. A review of the communication needs of the hospital was undertaken at the end of 2006 and led to structural and reporting changes, with effect from January 2007.

The communications framework and action plan were developed and implemented as a response to this review, to support the strategic objectives of the NHS board and reinforce commitment to continuous improvement of policies and procedures. In addition, further review of the communications framework and action plan is scheduled for February 2010. A communications review group was also established and is chaired by the chief executive. It meets on a 6-monthly basis and is the key vehicle for monitoring the communication strategies within the NHS board. The group is responsible for the implementation and ongoing development of the live action plan, and reports to the Board twice yearly. These reports provide an overview of key activity, highlight successes and identify areas for further improvement within the hospital.

Given the nature and organisational arrangements of the NHS board, patients are uniquely viewed as internal communication stakeholders in addition to NHS Board members and staff groups, and this is reflected in the internal communication strategy. Carers, the public and the media are encompassed within external communication arrangements. The internal communications strategy supports both the staff charter and the ‘well-informed’ aspects of the staff governance standard. It provides a framework to describe the process of communication, consultation and involvement of patients and staff in hospital activities.

The review team commended the robust methodologies that the NHS board has employed to ensure partnership working and the involvement of key stakeholders in the communication process. These include the development of the staff partnership forum, patient partnership group and carers reference group to ensure that all groups are communicated with and their views taken into account. These are reviewed alongside data analysis derived from internal staff surveys, annual patient experience surveys, national NHS staff surveys, suggestion box comments and the annual review process.

Patient communications are given high priority within internal communications, and patients are regularly encouraged to express their views to enable the NHS board to examine practices and systems. Methodologies for this include suggestion boxes; a regular patient partnership group, in which patients develop their own newsletters; bulletin and feedback posters; and a regular patient experience survey. The NHS board reported that 86% of all patients completed the last 2009 patient experience survey. Further evidence submitted demonstrates that the NHS board has tailored the way it communicates information to the specific needs of internal stakeholders, for example it was reported that face-to-face communication is the preferred method with patients.

The NHS board also has substantial processes for staff consultation and is listening to its staff, in addition to informing them. This is carried out in a variety of ways including an annual planning and development day whereby local delivery plans are discussed and updated; organisational staff briefings; reporting to the staff governance committee; team meetings; staff bulletins; the intranet; and emails.

The review team was pleased to note that, in regards to staff and patient communication, the NHS board has successfully developed a listening culture. The views of stakeholders are regularly sought and proactive surveys, with associated action plans to stimulate further strategic activity, are carried out.
The review team further noted that the NHS board’s evaluation and review process has been undertaken with sufficient scope, depth and clarity over time to clearly demonstrate a self-sustaining cycle of continuous improvement. In particular, a number of modifications have been initiated within the NHS board as a result of this cycle. These include documentation shelf life to prompt future automatic reviews; strategic stakeholder impact assessments; staff bulletin reviews and development of a quarterly newsletter to inform staff; a patient information ward scoping exercise, and the expansion and subsequent review of the patient partnership group.
Standard 3: Assurance and accountability

**Standard statement**
NHSScotland is assured and the public are confident about the safety and quality of NHS services.

**Overall performance assessment statement:**
The NHS board is monitoring the effectiveness of its arrangements to promote public confidence about the safety and quality of the care and services it provides.

**Core area: 3(a) Clinical governance and quality assurance**

**Performance assessment statement:** The NHS board is monitoring the effectiveness of its arrangements to co-ordinate clinical governance and quality assurance arrangements across the organisation.

A clinical governance strategy is in place for the period 2009–2012 and is supported by a number of other strategies including the risk management and clinical effectiveness strategies. The strategy lays out the arrangements for clinical governance including the framework for its delivery at the operational level, and the various committees and specialist groups which are in place to do this. The work of these committees is reported through two routes: to the HMT and also to one of the governance committees (ie the staff governance, clinical governance or audit committee). The HMT monitors the implementation of the various components of the clinical governance strategy and clinical governance is a standing item on the agenda of its meetings.

The clinical governance committee oversees the clinical governance arrangements. An annual work plan outlines the key tasks for this committee and the monitoring reports it will receive. A key objective of the clinical governance committee is to assure the Board that effective clinical governance mechanisms are in place. This committee is a sub-committee of the Board and has been given authority to investigate any areas within its terms of reference, as part of this assurance process. Individual directors have been given lead responsibility for the core areas within the clinical governance standards, with the medical director having overall responsibility for clinical governance. Clinical governance work is supported by the risk management and clinical effectiveness teams, and the head of clinical governance and risk is responsible for ensuring the co-ordination of the work of these teams. While commending arrangements in place for clinical governance, the review team encouraged the NHS board to consider further rationalisation of groups.

Under the direction of the nursing director, the NHS board is implementing aspects of the Scottish Patient Safety Programme. It is not required to implement the programme, however has developed its own unique response to the programme.

The review team commended the use of development days as a method of involving staff from across the organisation in clinical governance.

Departments report progress to the clinical governance committee using standardised templates. This committee has altered the style and content of the reports it receives, and it was reported that the quality of reporting has improved as a result. A similar but more
focused template is used within departments when feeding into the clinical governance annual report.

Evidence demonstrated that the NHS board has begun to evaluate its clinical governance arrangements. The feedback system ‘Compliments, Comments, Concerns and Complaints’ (the 4 Cs) plays an important quality assurance role, and its key focus is improving patient safety. The effectiveness of this system is reported and monitored in a number of ways, including quarterly reports to the clinical governance committee. It was reported that changes have been made to this system and that there has been an increase in the number of reports providing specific information on incidents for use within wards.

Furthermore, a policy mapping exercise was carried out in 2008 which looked at governance arrangements in place for policies. Following this exercise, the guidance on policy development was revised to more clearly outline the approval routes for new and revised policies. In addition, changes were made to the way policies are managed, for example a system was put in place to review policies to ensure that they can be used within the new hospital. These developments were reported in a paper to the clinical governance committee and key challenges looking forward were identified, such as rationalising the number of policies used within the NHS board.

Core area: 3(b) Fitness to practise

Performance assessment statement: The NHS board is implementing arrangements across the organisation that will ensure its workforce is fit to practise.

Evidence demonstrated that the NHS board has implemented arrangements across the organisation to ensure that its workforce is fit to practise. The staff governance committee is responsible for fitness to practise and provides assurance to the Board on people management arrangements. Also included within its remit is the monitoring of staff-related policies and procedures, specifically their development, implementation and review. Partnership working arrangements are in place between the staff governance and clinical governance committees to ensure that any staffing issues which affect patient care are also dealt with effectively. The employment practice group develops and reviews policies relating to fitness to practise. The NHS board reported that responsibility for fitness to practise arrangements lies with all clinical directors and also the interim human resources director.

Fitness to practise arrangements are supported by a number of policies and procedures. Mechanisms to identify staffing issues are outlined in policies such as the whistle-blowing and management of capability policies. It was reported that support is provided to staff on any issues which may impact their ability to carry out their duties, for example referral to the occupational health department. In addition, an employee mental health e-learning module is in place to help managers support staff who are suffering from stress. While commending mechanisms in place, the review team noted that a number of policies were out of date. The NHS board reported that this was as result of restrictions on partnership working relating to Agenda for Change between 2006–2008. Arrangements for partnership working had now been resolved and an action plan was now in place to update policies. The review team encouraged the NHS board to continue with the work already underway to review and update outstanding policies.
Employment checking arrangements are co-ordinated by the human resources department. Arrangements are in place to ensure that the necessary background checks are carried out prior to the employment of new staff. It was reported that all new clinical employees are subject to professional registration checks and that these are repeated annually. The review team was informed that monthly registration checks are carried out on staff across the site and that, should a registration have lapsed, appropriate steps are taken, for example an individual may be prevented from practising until their registration is reinstated. In addition, a local electronic human resources system has recently been put in place to help monitor pre-employment checks and professional registrations. The review team further commended the NHS board in their approach to employment checking for contractor staff, by inclusion of a contractual requirement and ad hoc compliance checking.

The NHS board is committed to ensuring staff have the necessary skills and knowledge to carry out their duties. Training courses are advertised via the staff bulletin, the intranet and also emails. Corporate training plans are developed each year outlining the range of statutory, mandatory, service linked and good practice training courses activities and these reflect training needs highlighted through the personal development plan (PDP) process. Evidence demonstrated that these plans are reviewed. Actual participation in training modules is listed alongside an assessment of the impact of the training. The review team was informed that staff feed in to the development of this training plan. For example, violence risk assessment was identified by staff as an area where more training was required; this was highlighted through senior charge nurse meetings. Directorate training plans are also developed annually. In addition, it was reported that a corporate database monitors activity to ensure that staff are trained in line with legislation and national standards.

A commitment to the NHS Knowledge and Skills Framework (KSF) was demonstrated. It was reported that every post has an associated KSF outline and that all staff have a PDP, which is reviewed annually. Furthermore, the NHS board has begun moving to the electronic KSF system and it is anticipated that this will be fully implemented by March 2011.

It was reported that clinical supervision arrangements are in place for all clinical staff. The nursing clinical supervision policy outlines the procedure for supervision and also the responsibilities of both the supervisor and supervisee. The review team was informed that the professional nursing forum is used to ensure that nurse practice development is taking place. The NHS board also reported that clinical supervision policies for specific disciplines were in the process of being drafted.

The NHS board is undertaking operational monitoring for example relating to effectiveness of training and clinical supervision. Additionally, it was reported that an internal audit of PDP/personal development review processes was carried out. However, the NHS board has not yet reached the stage where it is evaluating the effectiveness of its overarching fitness to practise arrangements across the organisation. The review team encouraged the NHS board to develop a structured, planned and documented approach, to allow it to reach the level where it is monitoring its fitness to practise arrangements.
Performance assessment statement: The NHS board is reviewing and continuously improving its external communication arrangements across the organisation.

As described in core area 2c, the NHS board’s communication and review arrangements are detailed within its communications framework and communications action plan, which is further underpinned by an internal communications strategy (2007–10), new hospital communications strategy (2006–10) and external communications strategy (2008–10). The external communications strategy identifies key stakeholders including those groups with a special interest in the NHS board; NHS and non-NHS partners; the public; and local communities. It also articulates a range of communication channels relating to each specific audience and examples of communication processes employed.

The NHS board also recognises carers as external stakeholders. A patient focus and public involvement carer policy is in place and extensive measures are employed to inform and consult carers. These include the maintenance and upkeep of a contacts database to ensure effective circulation of information; launch of a carers newsletter in 2007; carers section on the website; dedicated carers centre; carer representation on the patient focus public involvement steering group; and an established carers reference group that is involved in hospital projects. There is a comprehensive cycle of evaluation in regards to carer communication in the NHS board, and subsequent improvements have been initiated through snapshot reviews and carer surveys. The review team was also pleased to note carer involvement in patient initiatives, for example healthy eating, where carers and families are re-educated as to food and fluid options that should be brought in for patients.

Media awareness is a sensitive issue for the State Hospitals Board for Scotland and there is a detailed media protocol, which ensures that there is an established, structured and consistent approach for handling media enquiries across the State Hospital. The protocol is regularly reviewed by the communications review group and the chief executive takes the lead on media enquiries, supported by the SMT and head of communications. As part of the protocol, the NHS board challenges inaccuracies in media reporting in conjunction with the ‘See Me’ national anti-stigma campaign. The review team was pleased to note that a number of political figures have been invited to the hospital as part of the approach to raising awareness amongst the public.

There are also a range of corporate fact sheets available to the public, which provide a range of information on what the NHS board does and on the construction of the new hospital. A guide for visitors is also available, and gives helpful information on search and screening procedures on arrival at the site. The NHS board’s external website also provides important information to the public.

Given the unique nature of the State Hospitals Board for Scotland, interaction with the general public is significantly different to other NHS boards. Only a small percentage of the general public will use the services provided by the hospital. The public/interested parties can engage with the hospital through the website, Board meetings, corporate displays at public events, and through the annual report and the ABC guide to State Hospital information booklet. Website reviews and accessibility audits are regularly undertaken to evaluate effectiveness of information, as is the speakers’ directory; an initiative whereby hospital staff deliver presentations to community groups. The review team also commended the NHS board in being the first special health board in Scotland, and the UK, to be awarded the Investing in Volunteers quality mark. Public volunteers
work within the hospital to provide a befriending service to patients, work alongside the
spiritual and pastoral care team, and are involved in both the patient focus public
involvement steering group and patient partnership group.

Evaluation activity is comprehensive and includes systems, processes and outcomes. As
with internal communication, external communication was scrutinised in the 2006
communications review and forms an integral component of the ongoing framework and
associated action plan.

Core area: 3(d) Performance management

Performance assessment statement: The NHS board is reviewing and
continuously improving its arrangements for performance management across
the organisation.

A performance management framework outlines arrangements within the NHS board. A
local delivery plan is in place for the period 2009–2012 and outlines key objectives and
performance measures, and is linked closely to HEAT targets. Corporate objectives consist
of key milestones and targets from the local delivery plan, and actions to support these
strategic aims. Each aim or objective is allocated to a member of the senior team and plans
are in place to link these organisational objectives to the personal objectives of these
individuals.

The finance and performance director is the lead for performance management and is
supported by the general manager. In addition, the NHS board has recruited a
performance information manager since the last NHS QIS peer review visit. The SMT
meets quarterly as the risk and governance committee, and a range of corporate
performance management issues are discussed. The HMT oversees performance
management activity relating to a number of clinical targets, while the performance
management group focuses on areas relating to corporate, non-clinical targets.

Performance management information is presented to a number of committees, teams and
the Board. A range of performance information is considered by the performance
management group relating to, for example, sickness absence and overtime. Performance
management information is regularly discussed at HMT meetings and trends across all
wards are highlighted. A new process has been introduced whereby performance data from
a specific ward are discussed at the meeting, with this ‘spotlight’ approach enabling the
team to provide context to the information discussed. End of year performance reports,
which contain information of the organisational performance for the year, are considered
by the HMT and presented to the Board. Quarterly Board reports provide a high level
summary of organisational performance; performance against HEAT targets is listed,
alongside good practice and areas for improvement. Also, any challenges to the delivery of
targets are noted in the conclusion of these reports. The review team commended the clear
lines of reporting within the NHS board. However, the team also encouraged the NHS
board to ensure that all evaluation reports are considered by an appropriate committee,
which would help ensure a well-structured approach to evaluation.

It was reported that there is a performance management section on the intranet which
collates information from the performance management systems within the NHS board.
The review team encouraged the NHS board to evidence that performance management
data are being tested in a systematic way.
The NHS board is using the balanced scorecard system as a way of displaying performance management information. This is a live system which can be accessed on the intranet, and is used for HMT and clinical team performance reporting. Monthly key performance indicator (KPI) balanced scorecard reports are also submitted to the HMT. Evidence provided by the NHS board demonstrated that these data are being used to make improvements within certain areas. For example, evidence from the balanced scorecard and ICP variance analysis highlighted that rates of key worker attendance at case reviews was recorded as 32% between October and December 2008 and since then a series of incremental targets was introduced to encourage attendance. Improvements were seen as a direct result of this and attendance increased to 60% in May 2009. The NHS board reported further plans to increase attendance to 80% by September 2009 and 100% by March 2010.

Since the last NHS QIS peer review visit, the NHS board has reached the stage where it is reviewing its arrangements for performance management. Annual planning and development events form part of the review of performance management arrangements, and are attended by senior staff members, including the chairs of various specialist committees. Feedback is gathered on a number of plans and frameworks related to performance management, including the corporate risk register and local delivery plan.

A substantive review of planning and performance management systems was carried out in September 2008, involving an in-depth evaluation of structures, processes and outcomes. The need for an overall performance management framework was recognised; the performance management framework was drafted (and approved) shortly after this evaluation. The NHS board reported that, as a result of this review, the balanced scorecard system was revised. It was also reported that changes to the format of the local delivery plan resulted from this review; strategic outcome measures are now included in the plan. In addition, a mapping exercise was carried out at this time to determine which KPIs are in use within the NHS board. This exercise highlighted duplication of reporting, gaps in reporting and the possibility of streamlining the use of KPIs in some areas. While commending arrangements in place for performance management, the review team encouraged the NHS board to ensure that all review activity relating to this core area is well documented.

Evidence demonstrated that changes have been made to arrangements as a result of review, for example the performance management group was established following a review of the HMT. It was felt that meetings of the HMT had become too large and, as the focus at meetings was on a broad range of activity, attendees would often be looking at areas of work not relevant to them. Also, the need for a group with a strong focus on performance management was recognised. A performance management group was established and meets fortnightly. This group focuses on performance activity within the general manager’s directorate and closely monitors a range of KPIs relating to HEAT targets. The HMT now has a reduced membership and a more clinical focus. In addition, it was reported that the risk and governance committee was established following a review of reporting arrangements for the SMT.
## Appendix 1 – Glossary of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CGRM</td>
<td>clinical governance and risk management</td>
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<tr>
<td>CPA</td>
<td>care programme approach</td>
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<tr>
<td>HEAT</td>
<td>health, efficiency, access and treatment</td>
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<td>HMT</td>
<td>hospital management team</td>
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<tr>
<td>ICP</td>
<td>integrated care pathway</td>
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<tr>
<td>KPI</td>
<td>key performance indicator</td>
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<tr>
<td>KSF</td>
<td>Knowledge and Skills Framework</td>
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<tr>
<td>NHS QIS</td>
<td>NHS Quality Improvement Scotland</td>
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<tr>
<td>SMT</td>
<td>senior management team</td>
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Appendix 2 – Review process

Prior to Visit

- NHS QIS publishes standards
- NHS QIS finalises and issues self-assessment document and guidance
- NHS board completes self-assessment and submits with evidence to NHS QIS
- NHS QIS performance analysts review the self-assessment submission and produce a pre-visit analysis report, which is sent to the NHS board for comment
- NHS QIS sends self-assessment submission and analysis report to peer review team

During Visit

- NHS board presentation to review team covering local service provision
- Review team meets stakeholders to discuss local services
- Review team assesses performance in relation to the standards based on the submission and visit findings
- Review team feeds back findings to NHS board
- NHS QIS produces draft local report and sends to review team for comment
- NHS QIS sends draft local report to NHS board to check for factual accuracy

After Visit

- NHS QIS publishes local report
- Team leaders consider findings of all local reviews and NHS QIS drafts national overview
- NHS QIS PUBLISHES NATIONAL OVERVIEW

Local Report (State Hospitals Board for Scotland): Clinical Governance and Risk Management – March 2010

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Appendix 3 – Details of review visit

The review visit to the State Hospitals Board for Scotland was conducted on 10 December 2009.

**Review team members**

**Mike Winter (Team Leader)**
Medical Director, National Services Division, NHS National Services Scotland

**Robin Lawrenson**
National Clinical Performance Manager, Scottish Ambulance Service

**Douglas Marr**
Non-Executive Director, Scottish Ambulance Service

**Arlene Napier**
Acting Head of Safety, Governance & Risk, NHS Tayside

**David Robb**
Public Partner, Aberdeen

**Ruth Thompson**
Associate Director of Nursing, NHS Lanarkshire

**NHS Quality Improvement Scotland staff**

**Anne Hanley**
Team Manager

**Kathryn Paterson**
Project Officer

**Susan Lowes (Observer)**
Project Officer
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**NHS Quality Improvement Scotland**

**Edinburgh Office**
Elliott House
8-10 Hillside Crescent
Edinburgh EH7 5EA

Phone: 0131 623 4300
Textphone: 0131 623 4383

Email: comments.qis@nhs.net
Website: www.nhshealthquality.org

**Glasgow Office**
Delta House
50 West Nile Street
Glasgow G1 2NP

Phone: 0141 225 6999
Textphone: 0141 241 6316