Clinical Governance & Risk Management: Achieving safe, effective, patient-focused care and services
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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 NHS National Waiting Times Centre (NHS NWTC). This review visit took place on 14 October 2009, and details of the visit, including membership of the review team, can be found in Appendix 3.

Further information about the local NHS system can be accessed via the website of NHS NWTC (www.nhsgoldenjubilee.co.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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**Standard 1: Safe and effective care and services**

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**Standard 2: The health, wellbeing and care experience**

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**Standard 3: Assurance and accountability**

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**Strengths**

The NHS board has:

- firmly established risk management structures throughout the organisation.
- demonstrated a strong commitment to clinical effectiveness and quality improvement across the organisation.
- mature arrangements for clinical governance and performance management which have been subject to evaluation and improvement.
- comprehensive arrangements for both internal and external communication which have been reviewed.
**Recommendations**

The NHS board to:

- continue to examine the audit programme for clinical effectiveness to enable the effective use of audit outcomes.
- ensure that there is a documented, planned and systematic approach to evaluation.
- continue to develop key performance indicators (KPIs) across the standards.
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.

The NHS NWTC risk management strategy 2009–2010 outlines arrangements for risk management, including key responsibilities, structures, and escalation procedures. This strategy is supported by a work plan for the same period. The clinical governance and risk management group oversees the overall clinical governance and risk management agenda, and assures the governance committees that risks are being effectively managed. The clinical governance and risk management unit supports implementation of risk management systems and processes. The clinical governance and risk management group reports to the clinical governance committee quarterly. This informs the committee of progress across the risk programme of work and ensures that risk management information feeds into work taking place at executive level. The review team was pleased to note progress on risk management since the last NHS QIS peer review visit, in particular the risk management structures now in place.

The use of Datix is firmly established within the NHS board. The NHS board reported that it had begun to assess the effectiveness of the Datix system, and whether the system is meeting the needs of departments. The review team encouraged the continuation of this evaluation.

A corporate risk register is in place and evidence demonstrated that it is regularly updated and reviewed, and therefore responds to any new developments. For example, staffing issues related to the influenza pandemic were recently added to this register. General managers are responsible for ensuring the inclusion of identified risks within directorates on the directorate risk registers.

A wide variety of risk training is in place for staff. In addition, there are also support mechanisms in place such as guidance on the use of Datix and how to report an incident electronically. The NHS board reported an improvement in the quality of risk registers due to training which had taken place.
Mechanisms are in place for identifying, assessing and reporting risks at the operational level. These are supported by an incident reporting policy and procedure, which is outlined within the risk management strategy. It was reported that incidents and risks at local level are discussed by the management of specific departments, and then escalated for discussion at directorate level and by the senior management team, if appropriate. Risk information including incident reports and root cause analysis are discussed at directorate clinical governance group meetings, with these groups ensuring that any resulting actions are carried out. Evidence demonstrated the sharing of learning and potential risks between departments. The NHS board highlighted the use of mechanisms such as walkrounds (which are part of the Scottish Patient Safety Programme) to check that changes made in one department as a result of a specific incident or recognised risk, have been implemented elsewhere.

The NHS board has integrated its risk management processes with partner organisations and the review team noted the effectiveness of these arrangements. For example, an incident reporting form has been developed with the Scottish Ambulance Service so that any incidents which occur during transfers are flagged up to both organisations.

Evidence demonstrated consideration of the effectiveness of risk management arrangements, with the clinical governance and risk management group playing a key role in this. A review of risk management arrangements was carried out as part of a larger review of clinical governance reporting arrangements in 2008. The risk management steering group was incorporated into the newly formed clinical governance and risk management group, as the potential for duplication was recognised should the group continue in its former format. Risk KPIs are in place at strategic level relating to aspects such as response times to complaints and the completion of interim reports for root cause analysis.

The NHS board is also assessing the impact of risk activity on staff awareness. A clinical governance and risk management survey was carried out and contained questions relating specifically to risk such as knowledge of how to conduct a risk assessment.

Monitoring of arrangements is further demonstrated by internal audit such as the internal audit on risk management which was carried out in January 2009. It was reported that changes have been implemented in response to recommendations within this report. For example, a template describing management responsibilities and leads was formalised, and further support was given, through guidance, to senior managers to clarify where accountability lies. While the review team noted changes implemented as a result of internal audit reports, it highlighted that the NHS board has yet to develop a formal approach to responding to such evaluations. The review team encouraged continued evaluation to ensure the correct balance of responsibilities.

Core area: 1(b) Emergency and continuity planning

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

Incident management protocols are in place within NHS NWTC for the period 2009–2010. These clarify the three levels of contingency (routine emergencies, major emergencies and major incidents), and the role of the core and support team members. The requirement to test these protocols is recognised. The civil contingency planning group is responsible for
monitoring the NHS board’s responses to major incidents, in addition to its business continuity work.

The major incident protocol was recently tested after a major total power failure and a second power outage 2 months later. An action plan was developed following the major power failure, and a report was later produced, detailing progress against this action plan. The NHS board reported that minor alterations were made to the protocols following this real life event but that overall the protocols were found to be robust. A duty manager pack contains a range of tools including contact numbers and action cards. Changes were made to this pack following the major power failure incident to make it easier for staff to use. It was reported that desktop exercises have been carried out to test arrangements but that a planned 6-monthly testing cycle had not yet been implemented.

NHS NWTC involves key stakeholders in the development of its emergency planning and business continuity arrangements. The NHS board reported that formal arrangements are in place with NHS Greater Glasgow and Clyde in relation to emergency and continuity planning. The emergency planning team at NHS Greater Glasgow and Clyde provides support and advice to NHS NWTC, for instance in the drafting of local emergency plans. In addition, the nurse director sits on the regional emergency planning group.

A strategic business continuity plan is accompanied by an overarching business continuity planning policy. Specific business continuity plans are in place, and these include corporate, nursing and pandemic flu business continuity plans. The continuity planning group monitors progress within the business continuity agenda, liaising closely with directorate clinical governance groups. It was reported that plans are in place for this group to take on an increased role in the review of business continuity planning arrangements. The clinical governance and risk management group oversees business continuity planning. This group reports to the clinical governance committee on progress through quarterly monitoring reports. The nurse director is the executive director responsible for clinical governance and risk management arrangements and provides assurance to the Board.

The NHS board has recently updated its training on major incident and business continuity planning. It was reported this training took place for senior managers in July and August 2009, and departmental managers are to receive this training by March 2010. The NHS board reported that it had employed the use of online learning for business continuity planning to make it easier for staff to use training facilities.

Evidence demonstrated that NHS NWTC has implemented arrangements to enable it to respond effectively to the recent pandemic flu outbreak. A response team has been put in place and, supported by a range of working groups, manages these arrangements. A rolling action plan has been developed listing actions against progress to direct preparations for pandemic flu.

The NHS board is monitoring the different aspects of its business continuity planning arrangements. Absence management arrangements were subject to internal audit in 2008, and an internal audit on business continuity planning arrangements was carried out for the period 2007–2008. This report made a number of recommendations surrounding operational arrangements and evidence demonstrated that the NHS board has taken forward recommendations from this report. For instance, a board-wide business continuity plan is now in place, and business impact analysis is now incorporated into business continuity plans. In addition, a review of business continuity planning arrangements was recently presented to the clinical governance and risk management group, prior to submission to the clinical governance committee. Progress within a range of areas was
highlighted alongside recommendations for next steps such as further roll-out of the training schedule.

However, while it was reported that the major incident protocol has been reviewed, evidence did not demonstrate that the NHS board is evaluating its arrangements for emergency planning.

**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.**

NHS NWTC has a clinical effectiveness strategy in place for the period 2009–2010, supported by a clinical effectiveness work plan. The clinical effectiveness manager leads on the delivery of the clinical effectiveness strategy. The clinical governance and risk management group supports the delivery of the clinical effectiveness programme. This group reports to the clinical governance committee on clinical effectiveness via the clinical governance quarterly monitoring report. Monitoring templates, which summarise audit activity for clinical effectiveness within each directorate, form part of this report. The effectiveness of the templates for these reports has been reviewed. The format was then adjusted to better capture certain issues and also to ensure consistent reporting across directorates. Directorate clinical governance groups direct clinical effectiveness work at the directorate level.

Systems are in place for the sharing of information, good practice and lessons learned across directorates. Clinical information templates disseminated to directorates list published clinical information such as SIGN guidelines. Individual directorates decide whether action is required, and these templates are then used to report back to the clinical governance and risk management group on the details of the action to be carried out, and the nominated lead. A local clinical forum was put in place as a result of the recognition of the absence of a directorate-wide forum where clinical issues could be looked at.

A clinical education programme is in place. Recognition of the skills and expertise among staff within the NHS board has led to an increased focus on providing in-house training where possible. Nurse induction programmes and core training have been evaluated and improved to ensure the reflection of national/local programmes of work, in addition to mandatory training requirements. An induction presentation is carried out for nurses on clinical audit, and a training programme is available to senior charge nurses on clinical audit. Plans are in place to establish a clinical skills and research centre which will host, for example, a range of training suites. Evidence suggested that a range of stakeholders were consulted during the development of the business case and that building work is due to begin in November 2009.

Evidence demonstrated that NHS NTWC is monitoring its arrangements for clinical effectiveness. For example, plans are in place to move to a single quality strategy incorporating the NHS board’s governance strategies. It was reported that this strategy will incorporate a review of the clinical effectiveness strategy.

A clinical audit policy 2009–2010 describes the clinical audit process and details responsibilities for staff and key groups. The review team encouraged the NHS board to
continue to strengthen the audit programme for clinical effectiveness, such as agreeing objectives and key milestones, to enable the effective use of audit outcomes within the continuous improvement cycle.

The formation of a new quality reference group is further evidence that the NHS board is evaluating its clinical effectiveness arrangements. The NHS board reported that it had recognised the need to form a new kind of reference group which would provide a wider base of people to draw expertise from. This was as result of feedback which highlighted that lay members of some groups did not feel able to make a real impact. This group will be attended by a diverse range of people including volunteers and the first meeting of this group was scheduled for November 2009. The review team encouraged the NHS board to ensure that there is a documented, planned and systematic approach to evaluation. This would allow the NHS board to demonstrate that changes made to arrangements are as result of a co-ordinated review of current arrangements.
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 monitoring the effectiveness of its arrangements to provide 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 monitoring the effectiveness of its arrangements with a partnership approach to access, referral, treatment and discharge across the organisation.

A range of policies are in place across the NHS board to support the access, referral, treatment and discharge process. A discharge from hospital policy aims to ensure a co-ordinated approach to discharge of patients and details the responsibilities of those involved. A falls strategy is in place for the period 2008–2011. This identifies a proactive approach to the reduction of falls such as the use of patient assessments to highlight any necessary actions to be taken to decrease the risk of falls. A policy for consent to operation, anaesthesia or treatment details the necessary processes when gaining patient consent, and procedure to be followed when consent is refused. It recognises the importance of a well-informed patient and that the risks, benefits and consequences to any treatment are communicated.

Service level agreements are in place with referring NHS boards. A generic service level agreement template details requirements for these referrals, for example information requirements. It also sets out the process relating to transport, accommodation and discharge of patients. Referral flow charts are developed in conjunction with referring NHS boards. It was reported that referral flows are further assessed when the director of business services and the business services manager meet quarterly with referring NHS boards.

Patients are provided with information in a range of ways, including orally, in writing, and audiovisually, enabling them to make an informed decision. Guidelines for the production of communication material contain information on how to prepare patient literature and a helpful guide to writing. Leaflets are reviewed by the communications department to ensure that they are written in plain English. Pre-admission information packs are available to patients on specific surgical procedures. For example, a total knee replacement pack provides information on the operation itself and contains a guide to patients’ physiotherapy and occupational therapy. In addition to an explanation of how to do specific exercises, this pack also provides helpful tips for daily life following the operation, such as getting in and out of bed. The review team commended the standard of information available to patients.
The carers strategy highlights a commitment to work alongside carers throughout the discharge process, and an accompanying action plan lists a range of high level actions. The carers information book lists general help available for carers and highlights what to expect when someone they care for is admitted to hospital. It explains a carer’s role within this process and includes useful explanations such as the purpose of a ‘discharge plan.’ An information guide has also been produced for staff who are carers within the NHS board.

NHS NWTC has begun to monitor its arrangements for access, referral, treatment and discharge and a number of examples of evaluations were provided. An internal audit of the NHS board’s waiting times arrangements around booking and scheduling took place. The administration team was strengthened as result of this audit, resulting in the appointment of a full-time waiting list co-ordinator. A review of the cardiac intensive care unit took place, after concerns over the ability to meet waiting time guarantees were highlighted through committee structures. A number of groups were established to determine the cause of this problem and, after the need for two more intensive care unit beds was confirmed, funding was achieved to put these beds in place.

It was reported that other service reviews have been carried out, such as an internal review of outpatient services. Plans to change the location of these services have resulted from this review. In addition, it was reported that arrangements surrounding ‘18 weeks referral to treatment’ are currently being reviewed and that changes are being made as result of this, for example, to the referral management process. The ‘speak easy’ comments and suggestions scheme has also been evaluated. Areas for improvements were highlighted and it was reported that 47 ‘mini improvements’ were carried out by staff as a result of this evaluation.

The review team encouraged the NHS board to strengthen its formal evaluation processes and develop a systematic approach to documenting the monitoring activity taking place across access, referral, treatment and discharge.

Core area: 2(b) Equality and diversity

Performance assessment statement: The NHS board is implementing its arrangements for equality and diversity in accordance with legislation, national guidance and best practice across the organisation.

NHS NWTC is committed to ensuring that the services it provides meet the needs of its diverse population. Schemes and associated action plans are in place for race, gender and disability equality. Plans are in place to amalgamate existing equality schemes into one single equality scheme. The NHS board has begun to consider the other three strands of Fair for All (sexual orientation, spirituality and age). Work is under way on a sexual orientation action plan and evidence demonstrated a commitment to raising awareness of lesbian, gay and bisexual issues. The spiritual care policy has been revised, and it was reported that spiritual care volunteers now help the spiritual care lead deliver this part of the equality and diversity agenda.

Key managers lead on each of the six stands of Fair for All, incorporating equality and diversity into their managerial responsibilities. The review team encouraged the NHS board to continue to examine this arrangement to ensure that sufficient time is allocated to the delivery of the equality and diversity agenda.
A range of groups and committees support the delivery of the equality and diversity agenda. The equalities steering group is chaired by the human resources director, and the equality and diversity lead for each strand sits on this group. Progress is reported to the equalities steering group, which in turn reports quarterly to the involving people steering group. Quarterly monitoring reports to the clinical governance and risk management group, and clinical governance committee, contain an update on equalities activity.

NHS NWTC is consulting patients, the public and communities on its equality and diversity agenda. The equalities reference group includes lay members from the community. Through a national reference forum, set up in conjunction with NHS Health Scotland, the views of black minority and ethnic communities were sought when the race equality scheme was revised.

Mandatory equality and diversity training for staff is in place and the NHS board is considering the use of e-learning packages to complement this training. A workshop was held for the senior management team in July 2009 to increase knowledge and to facilitate discussion on specific challenges.

A protocol for conducting equality impact assessments is accompanied by a number of assessment tools and these have recently been updated. Much work has taken place around improving the equality impact assessment process, following the recognition of the need for a more robust system. The review team encouraged the NHS board to continue work in this area, to ensure a systematic approach to the completion of assessments across all new and existing policies.

Evidence demonstrated that the NHS board has begun to monitor its equality and diversity arrangements, for example governance structures have been evaluated resulting in the formation of an equalities group. However, the review team did not consider that there was enough evidence of a comprehensive and systematic approach to the evaluation of effectiveness of the NHS board’s 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.

NHS NWTC has reached the stage where it is reviewing and continually improving its arrangements for internal communication. The joint internal and external communications strategy has been fully implemented and monitored throughout the period since the last review in 2006. It has undergone a formal evaluation which has informed the creation of a new communications strategy for the period 2009–2012.

There is a comprehensive suite of internal communication methods including a quarterly staff magazine and a regular team briefing that follows the 6-weekly Board meetings. Following a review of emails to all staff, which included specific feedback from staff, the NHS board has implemented an ‘e-digest’. This is a weekly electronic bulletin that provides key updates to all staff in a concise and standardised format. It is also distributed in hard copy to staff who do not have email access. In addition posters, leaflets and bulletins are used on a needs basis.
The NHS board has a systematic approach to maintaining the effectiveness of its internal communication including the monitoring of distribution methods and accessibility of staff bulletins and magazines, and using read receipts to monitor accessibility of electronic communication.

The NHS board also has in place a range of ways for staff and service users to feedback on internal communications. This includes tear-off strips on staff bulletins, an email address for comments and the use of the NHS staff survey. In addition to the staff survey, the NHS board commissioned an independent survey by Ashbrooks Research & Consultancy to gain greater understanding of staff responses within the NHS staff survey. In addition, the communications team meets with all departments within the NHS board at least annually to gain an insight into how internal communications can further be improved.

The range of evaluation activities described have been incorporated into the creation of the new communications strategy for the period 2009–2012. This communications strategy was developed in conjunction with all major stakeholders and staff were invited to attend focus groups and one to one sessions to discuss it. Furthermore, staff and patient communications have been subject to internal audit. This clearly demonstrates that the NHS board is continually monitoring and reviewing its arrangements for internal communications and responding to the needs of the organisation by making improvements when required and ensuring these are further supported by up-to-date policies and strategies.
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.

NHS NWTC has a clinical governance strategy in place for the period 2009–2010. The strategy is supported by a clinical governance and risk management directorate unit generic work plan 2009–2010, which lists key objectives and milestones against progress during each quarter. The clinical governance committee monitors the implementation of the strategy which is supported by the clinical governance and risk management group, chaired by the chief executive. This group supports implementation at all levels throughout the NHS board. The clinical governance and risk management unit is responsible for the delivery of the strategy and organising activities to help staff with its implementation. In addition, directorate clinical governance groups assist staff within directorates to ensure the implementation of clinical governance at local level. The clinical governance and risk management development unit is represented on the senior management team to ensure that clinical governance and risk management work is given sufficient priority. While commending arrangements in place, the review team encouraged the NHS board to continue to explore ways to involve operational staff in clinical governance activity.

Directorate clinical governance groups report to the clinical governance and risk management group using clinical governance monitoring templates, which cover a range of indicators relating to clinical effectiveness, risk management and involving people. Quarterly monitoring reports are considered by the clinical governance and risk management group and the clinical governance committee, and summarise progress on clinical governance work throughout the NHS board. Evidence suggested that the composition of this report has been reviewed and altered after consideration of feedback from stakeholders.

Evidence demonstrated that NHS NWTC is evaluating its governance arrangements. Plans are in place to develop an overall quality strategy which will encompass the clinical governance strategy, and the supporting clinical effectiveness and risk management strategies. This decision was taken after evaluation of these individual strategies, and the recognition of changing national priorities, with an overall quality strategy aligning arrangements with national approaches. A working group has been put in place to take this forward, and it is planned that the quality strategy will go to the Board by March 2010.
There has been a period of extensive change within NHS NWTC, including the opening of the West of Scotland Regional Heart and Lung Centre. The review team commended the management of this change and the NHS board’s ability to deliver throughout this period. In response to structural changes within the NHS board, a review of clinical governance arrangements was carried out in the second half of 2008. In addition, the need for further clarification of clinical governance arrangements and structures was recognised. A number of recommendations were made and evidence demonstrated that changes have been implemented following this report. The risk management steering group and the clinical governance steering groups were merged into an overarching clinical governance and risk management group. It was recognised this would increase Board assurance and limit duplication of work.

Evidence demonstrated further evaluation of clinical governance arrangements. For example, arrangements within the theatre anaesthetics/clinical services directorate were modified after recognition that arrangements in place for a directorate consisting of such a varied group of professionals were no longer working. As result of this review, the directorate was split into two groups (theatres and medical physics, and clinical services), both reporting to the clinical governance and risk management group.

A clinical governance and risk management staff survey was carried out for the period 2008–2009, further illustrating the NHS board’s commitment to evaluating clinical governance arrangements. Information was collected on a wide range of factors relating to clinical governance, including risk management. The survey also looked at whether any barriers to clinical governance were present, such as lack of understanding of what it is or the culture within the NHS board. The clinical governance and risk management directorate unit will formulate an action plan which will become part of clinical governance plans already in place.

KPIs are in place for clinical governance and these are updated yearly. For example, a new target relating to *Clostridium difficile* infection in hospitals among patients aged 65 and over was introduced. The review team noted that KPIs are currently operationally focused and encouraged the NHS board to continue to develop its KPIs for clinical governance.

**Core area: 3(b) Fitness to practise**

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

Fitness to practise arrangements within NHS NWTC are supported by a range of policies and procedures. The recruitment and selection policy and procedure details recruitment and interview processes, alongside who is responsible for certain aspects of procedure, such as pre-employment checks. A sickness absence policy details procedure to be followed when an employee is unable to work, and highlights the responsibilities of both the employee and their manager. Tools are provided to managers to help them deal with absence among staff. It was reported that this has enabled the NHS board to exceed the HEAT target of 4% sickness absence; the figure for March 2009 was 3.68%.

A commitment to volunteers was illustrated by the volunteering policy and procedure, where it is explained that volunteers are given the same opportunities as other staff.
 Volunteers can take part in training when required for their role and are subject to comprehensive recruitment processes, in line with the procedure for paid staff.

Guidance for clinical staff involved in clinical supervision is provided by an overarching clinical supervision policy. It was reported that all new nursing staff take part in a preceptorship for a period of 6–18 months. A clinical educator or a senior charge nurse oversees this process, which allows any areas for improvement to be flagged up. An action plan is developed to support the improvement process. The review team commended the use of the preceptorship scheme.

A range of policies are in place to support staff and managers through the NHS Knowledge and Skills Framework (KSF), and performance development processes. The NHS board reported that it had met the HEAT target of 100% of staff having KSF-based personal development plans by 31 March 2009.

NHS NWTC is committed to ensuring that staff have the necessary knowledge and training to carry out their duties. A corporate learning and development plan 2009–2010 lists learning and development activity across all levels of the organisation, with progress reported to the staff governance committee and the workforce planning and development group. It was reported that training events are promoted through learning and development bulletins, the intranet and the staff magazine.

The NHS board has begun to monitor its fitness to practise arrangements. An internal audit was carried out in October 2008 of the workforce planning recruitment arrangements. Evidence demonstrated that the NHS board has taken forward recommendations from this report. For example, the recruitment policy has been reviewed. Various policies were brought together and policies no longer in use were removed. In addition, the NHS board is monitoring the effectiveness of types of media used in advertising jobs, following on from a recommendation within the internal audit report. Absence management arrangements have also been monitored through internal audit.

Core area: 3(c) External communication

Performance assessment statement: The NHS board is reviewing and continually improving its external communication arrangements across the organisation.

NHS NWTC has reached the stage where it is reviewing and continually improving its arrangements for external communications. The communications strategy for the period 2006–2009 was fully implemented and covered both internal and external communications. This plan has been routinely monitored and subjected to formal evaluations, the results of which informed the creation of the new communications strategy. At the time of the visit, the communications strategy for the period 2009–2012 was out for consultation with the relevant stakeholders prior to approval by the Board.

The NHS board has a strategy for involving people and a patient focus, public involvement policy. This ensures that key stakeholders are included in consultations for key changes and strategies within the NHS board area. The NHS board uses press releases to publicise all key events and has communications staff available to respond to media enquiries 24 hours a day.
The communications team also hosts a range of training events on customer care, media awareness and the use of plain English for staff and stakeholders across the NHS board area. There are specific communications activities set up for staff and the public to support projects related to major service development which include focus groups and briefings. There has been public and lay involvement in the development of all strategies, but specifically the customer care strategy, carers strategy, disability strategy and the race strategy. The NHS board also has well-established channels of communication to provide charities and support groups with targeted information on the services provided.

The NHS board performs a formal evaluation of the overarching communications strategy on a regular basis, which comprises of a wide range of surveys, focus groups and interviews. There is a quarterly report outlining the activity of the communications team, issues and developments discussed at the senior management team meeting, where the effectiveness of the arrangements are reviewed. The NHS board has also participated in benchmarking with other NHS boards and relevant public agencies, the results of which have been incorporated into the updated communications strategy. There has been a further audit fed into the development of the new strategy to ensure that progress is being made and that the NHS board is successful in achieving its aims, thereby demonstrating that it is reviewing and continually improving its arrangements.

**Core area: 3(d) Performance management**

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

The NHS board’s performance management structure was revised in 2006 with the resulting performance management framework approved by the Board in January 2007. The performance and planning committee was established to support the delivery of this framework. This committee is responsible for monitoring operational performance within the NHS board and is chaired by the chief executive. It reports to the senior management team, which then reports to the Board. The head of performance and planning plays a key role both in the development of overarching performance management policies and systems, and also supporting operational performance reporting. The NHS board reported that the performance and planning committee assesses a wealth of information that is presented to it and has the opportunity to challenge information. An example of this was the bed occupancy review. This review was assessed by the performance and planning committee before going to the senior management team.

Performance management information and data support decision-making at Board level. Clear structures are in place to enable collection of performance management information at local level and its subsequent escalation upwards, through the performance and planning committee. Local data are used to produce a performance monitoring pack. This pack provides a range of information, such as bed statistics and occupancy rates within directorates. These packs are considered by the Board, alongside directorate performance reports which illustrate progress against targets and help identify any emerging trends in performance. It was reported that the performance monitoring pack is continually evaluated to ensure it reflects evolving organisational priorities, further illustrating a commitment to continuous quality improvement within the NHS board. End of year reports, produced by the performance and planning committee, are provided to the Board, summarising performance progress within the NHS board.
Corporate objectives are produced yearly. The corporate objectives for 2009–2010 reflect local targets, while focusing on continual improvement and providing high quality service to patients. Corporate balanced scorecards list KPIs relating to clinical, staff, financial and operational governance, alongside targets and progress made within the reporting period. Separate performance indicators are listed for the Golden Jubilee National Hospital and the Beardmore Hotel and Conference Centre. These are considered firstly by the performance and planning committee, and then the Board.

NHS NWTC is kept updated of developments at the regional and national level through membership of groups such as the national performance forum and the West of Scotland regional planning group, and updates its performance arrangements where necessary.

Evidence demonstrated that the NHS board is monitoring performance in relation to local and national targets. The performance and planning committee is responsible for the local delivery plan. Work on this is delegated to the local delivery plan steering group, a subgroup of the performance and planning committee, which also ensures that performance arrangements are linked to strategic objectives. A 2008–2009 performance overview sets out progress against local and national local delivery plan targets within a range of areas including efficiency and access to services. NHS NWTC is monitoring achievement against targets set out within the local development plan for 2008–2011. An internal audit report lists whether targets have been fully, partially or not achieved.

The NHS board is continually evaluating its performance management arrangements through internal audit. The findings of the 2006 NHS QIS peer review visit had highlighted the need for a performance management structure which would ensure comparison of the NHS board’s performance against national and local targets. An internal audit report on planning and performance management (2007–2008) recognised progress made in the implementation of revised performance management structures. It highlighted good practice such as the consistent method of reporting to the performance and planning committee. It also highlighted the close working relationship of the general managers seen as result of this new structure, enabling them to share information from within their own directorate, which may affect work across other directorates. Evidence demonstrated that the NHS board is evaluating its performance management arrangements. The review team noted that a planned, systematic, and documented approach to evaluation would enable NHS NWTC to evidence that it is reviewing and continuously improving performance management arrangements.
### Appendix 1 – Glossary of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CGRM</td>
<td>clinical governance and risk management</td>
</tr>
<tr>
<td>CHP</td>
<td>community health partnership</td>
</tr>
<tr>
<td>HEAT</td>
<td>health, efficiency, access and treatment</td>
</tr>
<tr>
<td>KPI</td>
<td>key performance indicator</td>
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<tr>
<td>KSF</td>
<td>Knowledge and Skills Framework</td>
</tr>
<tr>
<td>NHS NWTC</td>
<td>NHS National Waiting Times Centre</td>
</tr>
<tr>
<td>NHS QIS</td>
<td>NHS Quality Improvement Scotland</td>
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Appendix 2 – Review process

Prior to Visit

NHS QIS publishes standards

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

After Visit

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

NHS QIS publishes local report

Team leaders consider findings of all local reviews and NHS QIS drafts national overview

NHS QIS publishes national overview
Appendix 3 – Details of review visit

The review visit to NHS National Waiting Times Centre was conducted on 14 October 2009.

Review team members

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