

NHS National Services Scotland

Local Report ~ April 2007

**Clinical Governance & Risk Management:  
Achieving safe, effective, patient-focused  
care and services**



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Every person using health services should expect these to be safe and effective. The NHS Quality Improvement Scotland (NHS QIS) clinical governance and risk management standards came into effect from November 2005. They have been developed to support NHSScotland to establish systems and processes, ensuring that care and services are safe and effective. This report presents the findings from the peer review of performance against the standards.

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NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. We do this by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

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The 'National standards for clinical governance and 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 nationwide.

This report presents the findings from the peer review of **NHS National Services Scotland**. This review visit took place on **20 December 2006**, and details of the visit, including membership of the review team, can be found in Appendix 2.

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In September 2003, a clinical governance and risk management standards project group was established and chaired by Dr John Browning, Medical Director, NHS Lanarkshire. The project group had a broad membership, drawn from a range of backgrounds, reflecting all dimensions of healthcare governance and representatives from interest groups.

The remit of the project group was to set standards for clinical governance and risk management, which integrated the healthcare risk management standards developed for NHSScotland by the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) and the generic standards (Clinical Standards Board for Scotland, 2002). These standards have, therefore, been designed to focus on clinical governance and risk management from the perspective of patient outcomes.

When developing the clinical governance and risk management standards, four focus groups were commissioned to ascertain public views on the standards. These groups were designed to capture a variety of perspectives from different geographical locations in Scotland.

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The review process has three key parts: local self-assessment, pre-visit analysis and external peer review. The review process is described in more detail below (see also the flow chart on page 9).

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On receiving the standards, each NHS Board assesses its own performance using a framework produced by NHS QIS. This framework includes guidance about the type of evidence (eg policies and reports) required to allow a proper assessment of performance against the standards to be made.

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On receipt of the self-assessment, NHS QIS performance analysts review the self-assessment and evidence, and produce a pre-visit analysis report which is given to the NHS Board for comment. Following discussion between the NHS Board and the performance analysts, this report is agreed and sent to the external peer review team, together with the self-assessment and evidence.

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An external peer review team visits and speaks with local stakeholders (eg staff) about the services provided. Review teams are multidisciplinary, and include both healthcare professionals and members of the public. All reviewers are trained. Each review team is led by an experienced reviewer, who is responsible for guiding the team in its work and ensuring that team members are in agreement about the assessment reached.

The composition of each team varies, and members have no connection with the NHS Board they are reviewing. Both of these factors facilitate the sharing of good practice across NHSScotland, and ensure that each review team assesses performance against the standards rather than make comparisons between one NHS Board and another.

At the start of the on-site visit, the review team meets key personnel responsible for the service under review. Reviewers then speak with local stakeholders about the services provided. After these meetings, the team assesses performance against the standards, based on the information gathered during both the self-assessment exercise, pre-visit analysis and the on-site visit.

The visit concludes with the team providing feedback on its findings to the NHS Board. This includes specific examples of local initiatives drawn to the attention of the review team (recognising that other such examples may exist), together with an indication of any particular challenges.

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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 development, implementation, monitoring and reviewing. These four key stages represent the continuous improvement cycle through which each NHS Board can ensure that all patients in hospitals 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 standard level statements will be added together and this assessment of performance will feed into the Scottish Executive Health Department (SEHD) Performance Delivery Unit in June 2007, and will be used to determine the NHS Board's targets for the following year.

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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 organisations who monitor other aspects of healthcare governance to inform the assessment process.

We have lead responsibility for assessing the performance of all NHS Boards against the clinical governance and risk management standards. By working together we share information and scheduling, ensuring organisations are not subject to unnecessary multiple reviews.

The organisations we are working with are Audit Scotland, Chief Scientist Office, NHS Education Scotland, NHS National Services Scotland, Scottish Executive Health Department, and Scottish Health Council.

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After each review visit, NHS QIS staff, with input as appropriate draft a local report detailing the findings of the review team. This draft report is sent to the review team for comment, and then to the NHS Board to check for factual accuracy. The local report will then be published and made available on the NHS QIS website.

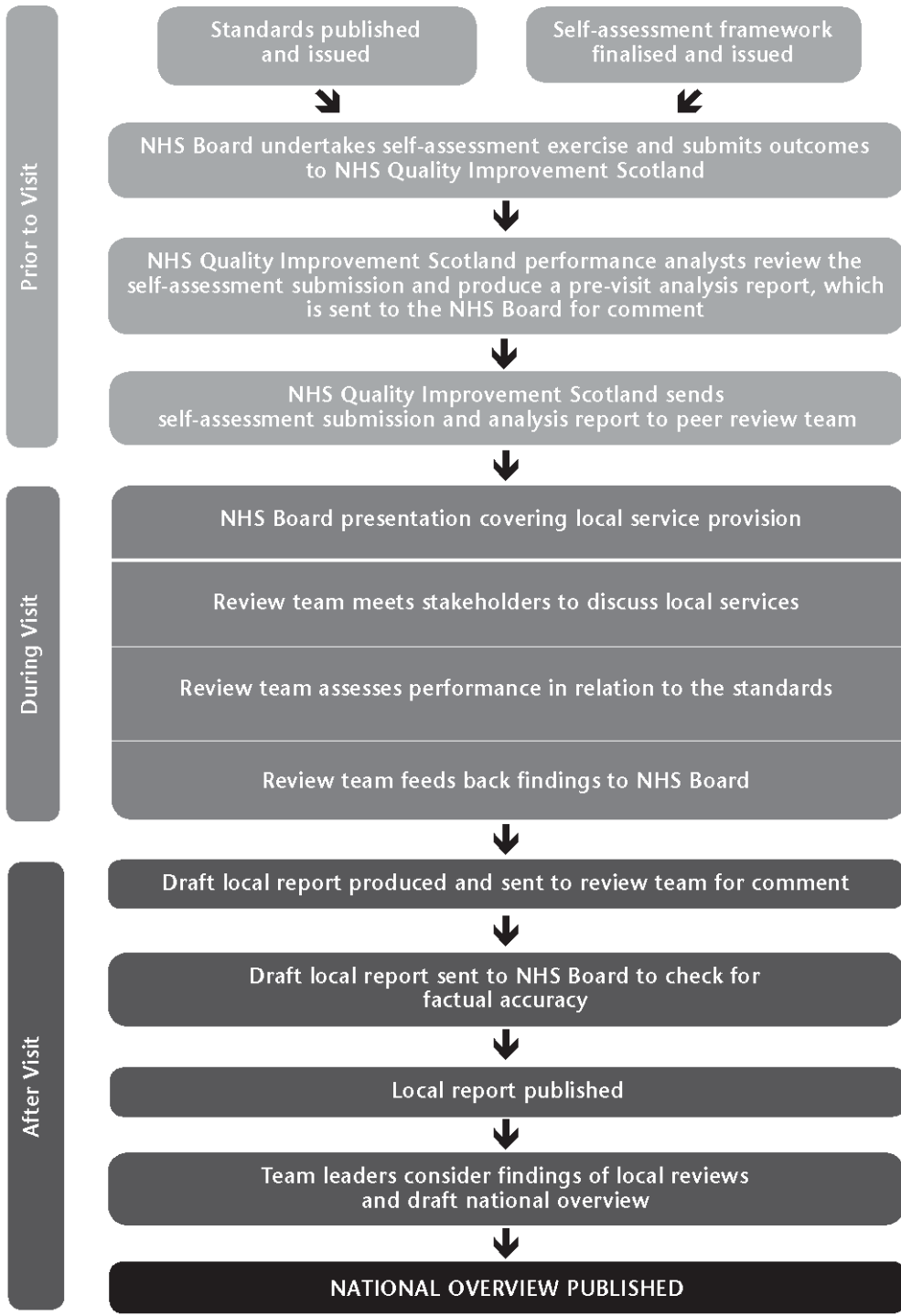
Once the clinical governance and risk management national review cycle is completed, the team leaders will meet to examine review findings and make recommendations. The team leaders then oversee the production of a national overview of service provision across Scotland in relation to the standards. This document includes both a summary of the findings and recommendations for improvement.

Part of the remit of NHS QIS is to report whether the services provided by NHSScotland, both nationally and locally, meet the agreed standards. This does not include reviewing the work of individual healthcare professionals. In achieving this aim, variations in practice (and potential quality) within a service will be encountered and subsequently reported.

**Please note – all reports published are available in print format and on the NHS QIS website.**

Quality Improvement Framework

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NHS National Services Scotland (NSS) is an integral part of the NHS in Scotland. It works to support health and frontline patient care by providing or co-ordinating essential national and regional services. These include:

Central Legal Office (CLO) - specialist legal services

Counter Fraud Services (CFS) - deterring, detecting and investigating fraud

Headquarters – providing corporate support to all divisions and services.

Health Facilities Scotland (HFS) – guidance to NHSScotland healthcare bodies on property management, building architecture, safety and clinical waste management.

Health Protection Scotland (HPS) - national surveillance of communicable diseases, environmental health hazards and public health

Information Services Division (ISD) - health statistics, analysis and information to inform decision-making

National Procurement - three main operational areas: strategic sourcing; eProcurement; and systems and logistics

National Services Division (NSD) - screening programmes and specialist clinical services

Practitioner Services Division (PSD) - family health service payments and patient registration

Scottish Healthcare Supplies (SHS) - value for money contracting and specialist commercial and technical services

Scottish Health Service Centre (SHSC) - conference facilities, event organising, library and information services, and national secretariat services

Scottish National Blood Transfusion Service (SNBTS) - blood transfusion services, tissue and bone banking services, and diagnostic products

Further information about NSS can be accessed via its website ([www.nhsnss.org](http://www.nhsnss.org)).

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A summary of the findings from the review, including examples of local initiatives drawn to the attention of the review team, is presented in this section. A detailed description of performance against the standards/criteria is included in Section 3.

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NSS has a robust risk register process in place and this is integrated within the divisions of the organisation. Each division has a risk champion responsible for cascading information on divisional risk registers to divisional senior teams and divisional partnership forums. The corporate risk register is discussed at corporate risk workshops, where risks to the organisation are identified and then allocated to an executive or divisional director who is responsible for the risks and the associated actions to address them.

Business continuity processes are well embedded in NSS, and business continuity plans have been developed. The organisation also has tested emergency plans and these and the business continuity plans have also been tested through exercises and in real situations.

NSS recognises that no single system approach to clinical effectiveness and quality improvement is in place in the organisation. However, individual divisions are involved in the development of clinical effectiveness and quality improvement programmes.

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NSS reported that no comprehensive policy and partnership approach was in place with regard to access, referral, treatment and discharge. Whilst individual divisions have developed their services in partnership with both the public and patients registered with other NHSScotland bodies, this was not consistent across the organisation. However, NSS recognises the need for all divisions to develop a sense of how their programmes of activity impact on patient care and the health of the population directly or indirectly.

NSS has a proactive approach to equality and diversity. Each division has an equality and diversity champion responsible for the operational duties required to meet the equality and diversity agenda. The organisation has evidenced frequent partnership working in its equality and diversity work and actively encourages the participation of lay representatives across the six strands of equality and diversity.

An internal communications strategy is well embedded in NSS. Communication with staff is facilitated through a number of methods, including newsletters and the corporate portal, geNSS, and staff input is actively encouraged.

**Internal Communications Strategy**

**Internal Communications Strategy**

Internal communications strategy is well embedded in NSS. Communication with staff is facilitated through a number of methods, including newsletters and the corporate portal, geNSS, and staff input is actively encouraged.

NSS has an organisation-wide clinical governance strategy which has undergone one review. At the time of the visit, five divisions had formal clinical governance committees in place. The organisation realises that a change in culture is under way and that all divisions, regardless of their proximity to direct patient contact, are realising their involvements in clinical governance and quality assurance.

NSS demonstrated a comprehensive approach to staff's personal development plans and the proactive approach taken to training. Many training opportunities are provided to staff and development opportunities are encouraged.

An organisation-wide external communication strategy for NSS is in development, however, a number of divisions currently have a strategy in place.

A performance management framework setting out high-level issues is in place within NSS. However, further work could be done to produce a fully integrated performance management system.

NSS has an organisation-wide information governance framework. The organisation also has a wide range of systems and processes to guarantee the confidentiality and security of personal information.

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mçéáíáÇá=ëí~íÉãÉáíWThe NHS Board is implementing its risk management policy, strategy, systems and processes across the organisation.

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Risk management is integrated within the divisions of NHS National Services Scotland (NSS) and is considered for all ongoing developments and projects. The framework for risk management has been developed using available guidance, including the clinical negligence and other risks indemnity scheme (CNORIS) assessments, and will be reviewed in the months following the peer review visit. Executive and non-executive directors attend the corporate risk workshops, where risks to the organisation are identified and actions and responsibilities are agreed. Each risk identified at the workshops is assigned to an executive or divisional director who is responsible for the risks and the associated actions to address them. The corporate risk register is presented to the NSS Board and its subcommittees. The executive management team and the partnership forum also have the opportunity to raise matters of concern relating to the corporate risk register.

The NSS Board has responsibility for risk management which is delegated to the audit and risk committee. Accountability for risk lies with the director of finance; this is delegated to the deputy director of finance and then to divisional directors. Divisional directors are responsible for their own particular areas of operation and work with the risk champions who are the catalyst for implementation. There is one risk champion in each division who cascades details of the risk register to divisional senior teams and the divisional partnership forum. Risk champions suggest changes to divisional risk registers, which are incorporated, for example a change to the format. However, the review team noted that it may be of benefit for the risk champions to have closer links to incident reporting, which would enable trends and transferable lessons to be identified.

Each division within NSS sets its own risks and these registers are ongoing, live documents which also contain an action plan and progress relating to the actions. Local divisional registers are not merged into one register as the divisions and risks are so diverse. Instead, the divisions highlight issues to be included in the corporate risk register, for example pandemic flu. Business plans include the risk register and are shared with all staff in divisions. Divisions also share risk information with staff through team briefings. If risks identified in divisions are not urgent then they are shared at risk champion meetings. If the risk is urgent then the divisional director

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escalates this by raising it at the executive management team. However, the review team noted that there is limited sharing of risk information between divisions.

The review team noted that NSS has a robust risk register system. However, it also recognised that, at the time of the review visit, this was the only source of risk management intelligence. Other systems are in place within the divisions, however these require to be pulled together into a Board approach.

NSS' risk management approach is communicated to staff through risk workshops to which staff representatives are invited. Outcomes of the workshops are made available to staff and methods of providing further information through the intranet are being developed. Mandatory training for staff on health and safety, work place assessment awareness and incident reporting is provided in the early part of employment, however, staff do not receive risk management training at induction. The Board reported that this may be included in future. Policy training programmes, for example recruitment, also cover risk issues in policy workshops.

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Staff employed by NSS are encouraged to report risks, incidents and near misses through posters, team communications and staff governance arrangements. Project managers are also encouraged to raise issues in relation to programmes, projects and services commissioned. Health and safety policies and guidelines contain information on reporting incidents. Incidents are reviewed by divisional health and safety staff and discussed at local health and safety committee meetings. Any matters of concern that are raised at divisional health and safety meetings are escalated to the occupational health and safety advisory committee (OHSAC). Analysis of critical incidents is reviewed annually in divisions and is then amalgamated corporately. However, the review team noted that the Board may benefit from taking a systematic approach to risk-alerting information (for example incidents and near misses). This may assist in learning from the information produced through trends identification and also in sharing cross-divisional transferable lessons.

The review team noted that NSS has not used the Australian/New Zealand Risk Management Standards to develop its risk profile. NSS recognises the usefulness of these standards, however, reported that it had difficulty in differentiating between two of the categories and challenges in changing thought processes to fit the standards. The matrix used by NSS is understood by staff and the traffic light system is consistent across the divisions.

NSS reported that internal auditors have facilitated workshops to assist with the standardisation and identification of risk. They have also provided assistance in laying out a 3-year programme to manage risks, for example clinical, human resources (HR), and finance. Audit Scotland has also produced an auditing risk-framework report, and there are robust links between internal and external audit. An audit actions register, which internal audit reports feed into, is in place. This is monitored quarterly and is reported to the audit and risk committee.

The review team recognised the bottom-up and top-down approach to risk management taken by NSS. The top-down approach is taken by internal audit to identify perceived corporate risks through workshops. Each division takes a top-down and a bottom-up approach to risk management where there is a

well-developed process for identifying the risks that affect them with the involvement of risk champions.

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Although the organisation is currently implementing its risk management framework, there was no Board-wide monitoring in place at the time of the visit. The review team noted that as there are no risk management objectives, it is not possible to demonstrate full monitoring. However, risk register action plans are monitored.

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As NSS has not demonstrated that it is monitoring its approach to risk management, there is not yet a process in place to undertake a review.

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**mçêáíçã-ëí-íÉãÉáíW**The NHS Board is implementing emergency and continuity planning systems across the organisation.

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NSS' responsibilities under the Civil Contingencies Act (2004) are to co-operate and share information with category one responders and other relevant planning partner organisations. These responsibilities are delivered mainly by the Scottish National Blood Transfusion Service (SNBTS) and Health Protection Scotland (HPS) divisions. NSS has adopted a framework and format for business continuity consistent with Business Continuity Institute guidance.

NSS is reliant on a number of external suppliers. Divisions within the organisation ensure that adequate business continuity is reflected in contractual arrangements. For example, National Services Division (NSD) discussions twice a year with national service providers that cover clinical performance, sustainability and continuity of service. Divisions also consult with stakeholders regarding the services provided to them as part of the business impact analysis.

NSS has organisation-wide business continuity and disaster recovery plans in place that have been developed by the business continuity planning group. This group is chaired by an executive board member and includes representatives from all divisions and support services including finance, HR, information management and technology (IM&T) and estates and facilities, as well as staff-side representation. The review team was pleased to note that business continuity processes are embedded across the organisation.

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NSS has tested emergency plans through involvement in a number of multi-agency exercises at regional level (for example Exercise Big Chill) and at national level (for example Winter Willow). Emergency plans are also tested when responding to real incidents, for example in relation to avian influenza (H5N1) and the Cellardyke swan. Outcomes of exercises and incidents are evaluated to ensure that lessons learned influence plans. The review team recognised the many links and connections that NSS has with NHSScotland with regards to emergency and continuity planning, and all other aspects of the peer review process. These links provide unique

opportunities for sharing areas of good practice throughout NHSScotland. For example, HPS has strengthened its health protection contingency arrangements by encouraging NHS Boards to have mutual support arrangements in place and share details of on-call rotas with HPS. This allows the on-call consultant to know what specialist health protection expertise is available in Scotland, if required.

During 2005–2006, work was undertaken to strengthen NSS' business continuity planning arrangements with the introduction of an organisation-wide crisis management plan. Divisions within NSS have undertaken workshops and exercises to test and appraise business continuity plans and have updated these to reflect lessons learned. In June 2006, the business continuity planning group conducted an organisation-wide desktop exercise to identify any gaps in the plans. This was followed by a walk-through exercise to test IM&T support and critical incident manuals. The NSS business continuity plan was also examined in February 2006 by internal auditors.

In November 2006, a fire affected NSS' procurement warehouse. Business continuity plans were implemented and the response was initiated at divisional and Board level. Following the fire, an interim distribution centre in a provisional building was operational 3 working days later. The review team was pleased to note this ability to respond to a major incident.

Divisional reports on business continuity are provided quarterly to the NSS Board and the executive management team. The business continuity planning group meets quarterly and updates plans quarterly and annually. The business continuity planning group also reviews these plans to enable learning to be translated into divisional action plans.

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The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NSS' approach to emergency and continuity planning was being monitored throughout the organisation.

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As NSS has not demonstrated that it is monitoring its approach to emergency and continuity planning, there is not yet a process in place to undertake a review.

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**mçéáííçá-ä-éí~íÉã ÉáíW**The NHS Board is developing co-ordinated programmes for clinical effectiveness and quality improvement.

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Individual divisions within NSS deliver distinctive national services to NHS Boards across NHSScotland. NSS reported that no common system of quality improvement exists, and the extent to which a single system approach can cover this wide range of clinical and non-clinical functions is limited. This is acknowledged by the review team, however, there is no overall framework that sets out how the divisions approach clinical effectiveness. Establishing clinical effectiveness arrangements is a matter that is delegated to divisions. Without an overall

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framework, the NSS Board faces a challenge in receiving assurance that these arrangements fit the needs of the whole organisation.

Individual divisions have developed a sense of how their programmes of activity impact on patient care and the health of the population directly or indirectly. This has been done by working with local structures and in consultation with external stakeholders where appropriate. The divisions have individually incorporated relevant clinical effectiveness and quality improvement programmes in annual business plans. The annual business plans feed into the NSS corporate business plan and local delivery plan. Divisional clinical governance and quality assurance structures have a key role in monitoring progress against agreed targets, and reporting significant issues and or variances to the NSS clinical governance committee.

NSS involves stakeholders and staff in the development of clinical effectiveness and or quality improvement programmes through: formal and informal consultation; appropriate stakeholder representation on joint working groups and programme boards; customer and staff surveys; feedback from Scottish Executive Health Department (SEHD) sponsors; and relevant national and local committees and groups. The service redesign committee also includes three places for staff representation. The services provided by NSS do not depend on contributions from the independent healthcare sector. Detailed and comprehensive quality clauses in contractual arrangements govern third-party service provider's contributions to clinical effectiveness and quality improvement (for example relating to IM&T or equipment).

NSS has many targets in place within divisions to drive continuous improvement in the health of the population. For example, targets for accuracy and turnaround times for dental, ophthalmic, pharmacy and medical payment processing within the Practitioner Services Division (PSD). Direct measures to monitor the improvement of the health of the population include measurement of the number of decayed, missing and filled teeth. Indirect measures include a wide range of health and health service statistics developed and published by the Information Services Division (ISD). New screening and specialist services are examples of key achievements in improving the health of the population.

Individual directors within NSS assume responsibility for ensuring implementation and compliance with national standards, guidance and policies. The lead for clinical effectiveness rests with the medical director of NSS, supported by divisional medical directors in four divisions. The nurse director is responsible for the implementation of standards, policies and guidance relating to nursing. Other directors, including the HR director, have specific responsibilities in this area as they relate to their roles. Compliance and performance against the standards is achieved through the NSS' performance management arrangement. This includes strategic performance review meetings between the chief executive and senior team members and divisional directors and their senior team. A comprehensive agenda includes the opportunity for detailed exploration of compliance and performance against appropriate standards, guidance and policies. The outcomes of those aspects of the strategic performance review meetings relating to clinical governance are reported to the clinical governance committee.

Trends in the number of complaints are considered by the clinical governance committee. Individual complaints are reported in detail where they merit individual consideration. The national staff survey has been analysed in-house by specialists in ISD to achieve more user-friendly information relevant to individual divisions and staff groups. Performance is measured in each division, and divisions report their response to complaints to the clinical governance committee. A mean response time to complaints has now been calculated further to the request by NHS Quality Improvement Scotland (NHS QIS) in the clinical governance and risk management self-assessment. The review team noted that most complaints received by the organisation are regarding services provided by a third party. The review team was pleased to note that the organisation seeks authority from those who have sent in a complaint if it needs to be redirected, before it is sent to the appropriate department. The Board reported that the complaints procedure had been formally approved at the clinical governance meeting in the week prior to the review visit.

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The review team was provided with evidence that local programmes of clinical effectiveness and quality improvement are being implemented within some parts of NSS, but that this is not consistent across the organisation.

**j çãíçéããÖ=**

As NSS is yet to implement an organisation-wide clinical effectiveness and quality improvement programme, it is unable to put a system of monitoring in place.

**oÉî áÉí áãÖ=**

As NSS has not demonstrated that it is monitoring its approach to clinical effectiveness and quality improvement, there is not yet a process in place to undertake a review.

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mçéáíáçá=éí~íÉãÉáíWThe NHS Board is developing policy and a partnership approach to access, referral, treatment and discharge.

**aÉíÉáçéãÉáí=**

The agency status of NSS requires the organisation to provide and co-ordinate a complex range of national health and support services. NSS reported that no comprehensive policy and partnership approach to access, referral, treatment and discharge is in place across the organisation. While the Board acknowledged the challenges of single system working with regard to its clinical and non-clinical functions, NSS is committed to addressing this.

NSS' strategic corporate plan 2004–2009 identifies a number of key objectives with regard to patient care including: national screening programmes; commissioning of specialist national services; provision of direct health advice; access to family health services; and provision of information to the public. NSS' draft patient focus and public involvement (PFPI) plan, which sets out each division's responsibilities, was approved at the December 2006 clinical governance committee. The designated director of public involvement formally assesses the organisation's progress against the plan with lead responsibility devolved to the clinical governance committee, a subcommittee of the Board. As detailed in the clinical governance committee's clinical governance template, each division is responsible for inclusive partnership working. Reporting arrangements are in place between divisional governance groups and the Board's clinical governance committee.

Individual divisions within NSS are responsible for promoting their health and support services. SNBTS seeks to recruit and retain donors through advertising campaigns, a dedicated SNBTS website, and by conducting awareness-raising visits to schools. SNBTS donor leaflets are produced in a number of formats, including large print, multi-lingual versions and Braille. SNBTS has also been working with Deaf Connection, Glasgow, to explore the obstacles faced by deaf and hard of hearing people. In addition, SNBTS provides written information for patients with specific disorders through its clinical apheresis units. The work undertaken by these units involves a procedure in which specific components of donated blood are removed before the remaining blood is returned by transfusion to the donor. Monitoring of the value and relevance of this and other information is undertaken through focus groups and via ad hoc patient surveys.

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NSD works with NHS Health Scotland to produce information materials for use by NHS Boards, including posters and leaflets. The division also works with NHS Board stakeholders to design specific screening programmes and genetic testing for identified at-risk groups, for example women with familial risk of breast cancer. To ensure that members of the public have access to the appropriate facilities, NSD works with service delivery stakeholders to arrange outreach mobile screening throughout Scotland. This work involves liaising with local authorities, supermarket chains and other agencies to ensure accessibility, for example in supermarket car parks.

The Board reported that the National Procurement Division has recently negotiated a travel contract for NHSScotland. The division liaised with NHS Boards and airlines to change flight schedules, therefore ensuring that patients from the islands are able to travel home from mainland hospitals on the day of discharge.

### **fã éäÉã Éáí - íáçâ=**

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NSS' policy and partnership approach to access, referral, treatment and discharge was being implemented across the organisation.

### **j çääíçéääÖ=**

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NSS' approach to access, referral, treatment and discharge was being monitored across the organisation.

### **oÉî äÉí ääÖ=**

As NSS has not demonstrated that it is monitoring its approach to access, referral, treatment and discharge, there is not yet a process in place to undertake a review.

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**mçääíáçâ-éí-íÉã ÉáíW**The NHS Board is monitoring the implementation of its equality and diversity policy across the organisation.

### **aÉî Éäçéã Éáí=**

The staff governance committee has responsibility for overseeing equality and diversity within NSS. This is a standing committee of the Board. The equality and diversity group comprises champions from across NSS' divisions and is responsible for overseeing the operational duties required to implement action plans relating to equality and diversity. Since 2005, an advisory equality and diversity forum has been working to assist the Board's progress with its equality and diversity agenda. The forum is chaired by NSS' chairman and comprises external expert advisors representing the six strands of equality and diversity.

### **fã éäÉã Éáí - íáçâ=**

NSS has adapted the SEHD impact assessment toolkit to make it more relevant to the work of the organisation. It is a pre-requisite of the Board that all policies are equality and diversity impact assessed before submission. To facilitate this, a covering sheet accompanies all board papers and includes equality and diversity

implications as a standing item. Where specific equality and diversity issues are identified, a detailed rationale is required before endorsement by the Board.

The equality and diversity co-ordinator reports to the staff governance committee and is responsible for ensuring that the needs of specific groups and individuals are met. Each division seeks to include representatives linked to the six strands of equality and diversity, but this is sometimes a challenge depending on the service being delivered. Where divisions provide direct clinical services, this is conducted with specific groups, for example SNBTS working with Deaf Connection, Glasgow, to encourage deaf and hard of hearing people to donate blood.

NSS strives to be inclusive in its delivery of clinical and non-clinical services. One key project for achieving this is NSS' equality and diversity information project (EDIP). The project is managed by ISD and uses a data-gathering mechanism to compile datasets for race equality throughout healthcare. The Board reported that it intends to apply this mechanism to collect other strand data in healthcare. In addition, for race equality, the National Procurement Division has produced a race equality and procurement guide. The guide has been adopted by all NHS Boards as well as some other non-health public bodies. As with EDIP, the Board reported that it intends to produce similar guidance for the remaining five strands of equality and diversity.

The review team received evidence of a comprehensive and focused approach to equality and diversity across the organisation. At the point of induction, HR ensure new staff are aware of the equality and diversity policy and how to access it, for example through the corporate portal, geNSS. To reinforce this, in 2006 all staff undertook equality and diversity awareness training. Courses were conducted via an online computer programme and 2-hour training sessions for staff without direct access to a PC.

### **j çãíçéããÖ=**

The NSS race equality scheme has been developed to meet the requirements of Fair for All. Since the scheme's formal publication in 2005, the organisation has been using the National Resource Centre for Ethnic Minority Health 'checking for change' performance indicator framework to monitor the performance of its impact assessment processes. This provides the Board with assurance that NSS is fulfilling its requirements under the Race Relations Amendment Act (2000). The Board reported that all impact assessments have been revisited since an initial exercise in 2003, with the resulting updates expected by March 2007.

NSS is also making good progress with regard to the other five strands of equality and diversity. For disability, the organisation is accredited with the 'two ticks' symbol for recruitment and ensures accessibility to its buildings through external audit. At the time of the visit, NSS had recently published its disability equality scheme. Monitoring of the scheme's performance will be undertaken using the equivalent of 'checking for change' key performance indicators.

### **oÉî áÉî áãÖ=**

At the time of the visit, NSS had not begun an organisation-wide review of its equality and diversity policy, however the following instances of reviewing were noted: regular updates to the NSS Board and staff governance committee; quarterly

review of progress at the equality and diversity meetings; and twice yearly updates to the equality and diversity forum.

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**mçëííçã-ëí~íÉã ÉáíW**The NHS Board is implementing its policies, strategies and procedures to improve the way that staff communicate and engage with each other, patients and the public across the organisation.

**aÉí Éäçéã Éáí=**

NSS has developed a comprehensive internal communications strategy with clear structures and processes for implementation. The design and content of the strategy involved both stakeholder and staff-side representation and has been approved by the partnership forum and the Board. The Board reported that, at the time of the visit, a performance management system for monitoring the strategy was in the development stage.

For individual projects and activities, NSS develops project-specific communication plans including: an internal communications matrix designed to support the sale of Alba Bioscience (a unit within SNBTS) and the protein fractionation centre, and a co-location newsletter for staff affected by the organisation's relocation to Glasgow.

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The review team noted that NSS' communication mechanisms are well implemented across the organisation. A corporate communications group comprising communications representatives from each division is actively involved in the development of policies and procedures. Staff awareness of these strategies, policies and procedures are raised at the point of induction. This is further reinforced with further specialist training for key staff, through articles in the monthly newsletter, and via the corporate portal, geNSS.

NSS officially launched geNSS in 2006 following stakeholder and staff input into the portal's design and functionality. Staff are able to access a broad range of information via the portal, including HR policies on bullying and harassment, equal opportunities, and stress and mental health. At the time of the visit, the Board reported that a design group and a best practice group have undertaken post-project evaluation of geNSS. Both groups are comprised of members from across the divisions and their findings will be used to inform the next stage of the portal's development, for example refining business systems by introducing online forms.

Two-way communication with staff is encouraged across NSS. One mechanism for facilitating this is via communications and geNSS email boxes. In addition, the organisation's newsletter, 'Pulse', is produced and disseminated to all NSS staff on a monthly basis. Individual divisions have voluntary article co-ordinators who act as a point of contact for staff who wish to provide input and feedback on the newsletter's content. The Board also reported on a number of intradepartmental and division-specific publications, including 'The Financial Statement' for divisional finance departments and the SNBTS quarterly staff newsletter, 'Bloodletter'.

The review team agreed that a particular challenge faced by NSS is guaranteed staff access to the corporate portal, and, therefore, key organisational policies and

procedures. Whilst important information is also circulated to staff through emails, the review team drew attention to the possibility of portal 'downtime' and to the 400 SNBTS staff who do not have direct access to a PC. However, the latter issue has been recognised and other mechanisms continue to be developed for these staff.

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NSS requires to finalise the monitoring framework for its communications policies, strategies and procedures before routine monitoring can take place. However, ad hoc monitoring and feedback occurs with regard to specific activities, for example a formal review of telecommunications following the Cellardyke swan incident.

#### **oÉî áÉî áÖ=**

As NSS has not demonstrated that it is monitoring its approach to communications policies, strategies and procedures, there is not yet a process in place to undertake a review.

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mqēáíāçā-ēí-íÉāÉáíWThe NHS Board is implementing its policy and strategy to co-ordinate clinical governance and quality assurance arrangements across the organisation.

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NSS has established a clinical governance committee as a subcommittee of the board. The clinical governance committee has delegated authority from the Board to review and approve annually the clinical governance and audit programmes submitted by all divisions, and to ensure that each division has a process in place to monitor and report clinical governance issues. It also receives quarterly reports from each division on progress against clinical governance and audit plans. Where specific incidents arise, there is also an opportunity for papers on these to be submitted to the clinical governance committee in addition to the normal route being followed. The committee also assesses the standards of clinical governance by measuring them against the Goals for Clinical Effectiveness, MEL(1999)76, and drafts a clinical governance report for inclusion in NSS' annual report.

The proceedings of the clinical governance committee are reported routinely to the Board. This committee developed a clinical governance strategy in 2005 for the whole organisation which has undergone one annual review by the clinical governance committee. However, not all divisions of NSS have equal contact with patients, therefore, there is a gradation in the intensity of clinical governance activity between divisions. The NSS medical director is the senior manager with lead responsibility for clinical governance.

NSS recognises that a change in culture regarding clinical governance is occurring. Initially the organisation felt that clinical governance applied only to direct patient services. Now it is recognised that indirect services impact eventually on patient care, and a shared understanding which considers many aspects of quality improvement is continuing. The review team recognised the effectiveness of the NSS Board and its efforts towards single system working, reflected in the annual report as 'one organisation, one mission, one vision'.

The review team noted that, although the Board receives minutes of the clinical governance committee and the clinical governance committee receives a summary of the divisional clinical governance committees, no monitoring of systems and procedures takes place. Clinical governance is being implemented within different

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divisions, however there is no single system consistent approach across the organisation.

Links between the clinical governance committee and staff governance committee are being explored. A protocol demanding work between the chairs has been developed to assist in the sharing of information. At the time of the visit, there were no protocols between the audit and risk committees – however, it is envisaged that this will be developed in the future. Each main governance committee will also be a standing item on other committees and minutes will be shared to ensure that all issues are being covered.

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All divisions within NSS that have a direct clinical or public health focus have clinical governance committees and structures. At the time of the visit, five divisions had formal committees. Divisional clinical governance committees and structures report quarterly to the clinical governance committee. Since 2005, clinical governance has been a standing item at divisional strategic performance review meetings, where a self-reporting template provides the basis for reporting. The self-reporting template has been modified and the updated version was used in the autumn 2006 round of strategic performance review meetings with divisions. The template is used against six dimensions of clinical governance and the divisions have a specific set of questions that they are expected to answer.

Divisional clinical governance committees and structures promote awareness among staff of the importance of clinical governance and quality assurance. Ongoing activities throughout NSS, such as ongoing staff training and divisional continuous professional development programmes, also promote awareness.

Arrangements and service-level agreements with other agencies vary across divisions depending on the services involved. For example, SNBTS' quality assurance directorate carries out routine inspections of premises and services of their suppliers (for example bag manufacturers). A further example is PSD which has service-level agreements with, for example, NHS Boards, Scottish Dental Practice Board, Scottish Health Service Research Unit and SEHD.

Divisions of NSS involved with research have established procedures regarding ethical implications of their work. For example, within ISD, there is a formal application process through the privacy advisory committee for any studies that involve the release of patient-specific data or record linkage. NSS is currently considering the way forward regarding the implementation and embedding of the principles and practices of research governance across the organisation. Actions have been identified and this work is progressing under the direction of the NSS medical director and the clinical governance committee.

### **j çãíçéããÖ=**

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NSS' approach to clinical governance and quality assurance was being monitored throughout the organisation.

### **oÉî áÉî íãÖ=**

As NSS has not demonstrated that it is monitoring its approach to clinical governance and quality assurance, there is not yet a process in place to undertake a review.

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mçéáíáçã-éí~íÉã Éá íW The NHS Board is implementing its policies and procedures across the organisation that will ensure its workforce is fit to practice.

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NSS has in place a range of policies and procedures relating to their fitness to practice framework. The recruitment and selection policy is based on partnership information network (PIN) guidelines. This policy also forms part of the policy workshops which are delivered to managers. In the future, all managers undertaking recruitment will have to sign up to management guidelines, currently in development, before they can participate in the process.

All candidates interviewed for posts within NSS are required to provide: original educational certificates; evidence of eligibility to work in the UK; and any professional accreditations. Before a candidate can become an employee the following is obtained: two satisfactory references; occupational health clearance; rehabilitation of offenders declaration; and Disclosure Scotland. All contractors and temporary employees are required to undertake Disclosure Scotland checks where appropriate. The employing agency has the responsibility to undertake pre-employment checks, however, for particular posts (for example nurses) only registered agencies are used. All staff also receive an induction and an induction CD has been produced.

NSS checks that staff have renewed and updated their registration/accreditation through an annual review cycle, where line managers require staff to produce their renewed registration/accreditation. HR staff check general medical council and general dental council registrations via an online process. The HR director and medical director confirm checks have taken place and highlight any issues to the clinical governance committee who notify the board. Quarterly reporting on staff and HR issues is also provided to the NSS partnership forum, staff governance committee and Board.

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At the time of the visit, NSS reported that 79% of staff had a personal development plan (PDP). As part of the staff governance action plan, setting of objectives will be reviewed, and it is envisaged that the number of staff with a PDP will increase. The review team was pleased to note the comprehensive approach to PDPs, proactive approach to training and the Investors in People accreditation gained by the organisation.

NSS also has a corporate learning guide which aims to provide training to equip staff and managers with the required skills and knowledge for their continuing development, for example CV writing and policy workshops. There have been two knowledge and skills framework (KSF) pilot sites within NSS, and further awareness sessions are due to take place. However, the organisation did realise that, at the time of the visit, not as much progress had been made regarding KSF as had been hoped

due to Agenda for Change. There is also an online tool in place which is designed to support managers in the development of their people management skills. The organisation has seven learning centres across Scotland which give staff access to a range of online development opportunities. The HR database, Peoplesoft, has also been developed to accurately record individuals training and development records. All development opportunities are promoted via the corporate portal, learning guides, email, learning centre open days and through line managers.

Within NSS, the medical director has responsibility for medical staff, nursing director for nursing staff, and HR and workforce development director for staff governance. At the time of the visit, the medical director also had responsibility for dental staff, however, a senior dental advisor is being appointed who will have responsibility for all dental staff. Divisional directors are responsible for scientific staff within their operational area.

### **j çáíçéáãÖ=**

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NSS' approach to fitness to practice was being monitored throughout the organisation.

### **oÉî áÉî áãÖ=**

At the time of the visit, the Board was unable to demonstrate reviewing of its fitness to practice arrangements across the organisation.

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mçéáíáçã-ëí-íÉã ÉáíW The NHS Board is developing its external communication strategy.

### **aÉî Éãçéã Éáí=**

At the time of the visit, NSS did not have a single system communications strategy, however, a subgroup of the corporate communications group has been formed to develop this. The Board envisages that a corporate external communications strategy will be in place by March 2007. The review team noted that this will enable the organisation to move to a system of developing a framework for all divisions to work to. However, they also noted that a number of divisions, programmes and national initiatives do have external communications strategies in place. The review team recognised that NSS is a diverse organisation with many strengths, although a challenge to the organisation may be the development and implementation of a single system external communications framework, including a set of standards. However the review team did note that this could provide a unique opportunity for NSS to gather information from other NHS Boards.

The NSS' media communications policy was developed in consultation with the organisation's divisional media contacts and with an external representative of the media. This is supported by a media relations handbook which includes best practice advice for dealing with the media.

NSS uses a range of methods to communicate with external stakeholders. A range of newsletters are produced weekly, monthly or quarterly, which either target a particular professional audience (for example NHS dentists), or focus on a particular



framework is high level and sets issues out clearly. The review team also recognised that NSS has all the correct elements of performance management in place. However, it is necessary for these to be addressed in an integrated fashion. The Board reported the appointment of a director for strategic planning and performance management and it is hoped that this appointment will bring focus and direction. The post holder will be involved in developing the strategic plan and measuring performance management. He will also be responsible for engaging the involvement of stakeholders in the service and encouraging more external communication.

Six-monthly updates in the corporate business plan, and quarterly updates in the local delivery plan on achievements and non-achievement of objectives are presented to the Board.

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Divisions within NSS submit performance updates in line with the timescales required by the divisional strategic performance reviews, local delivery plan and NSS accountability review. The local delivery plan is updated and reported to the Board and then to the SEHD quarterly. Key performance indicators are established which relate to the delivery of the business objectives. Performance assessment is initially carried out at divisional level and reported to the divisional senior management teams. These senior teams then review this and take appropriate action to ensure the delivery of the agreed performance. Divisions also submit a summary report against the local delivery plan key targets twice a year to the Board. This uses a traffic light system to show the status of progress against the key targets.

Key performance indicators are established within divisions to enable benchmarking to take place against performance. Strategic performance reviews are then undertaken every 6 months, which recognise good clinical governance. These are assessed within the divisional management teams and discussed with stakeholders, sponsors and the public during service reviews. For example, in NSD and SNBTS, benchmarking against UK and comparable international services is possible.

The clinical governance committee has approved the framework for clinical requirements monitoring within the overall performance review process. It is envisaged that the clinical governance template will ensure consistent consideration of the delivery of service while recognising clinical governance standards. The template is completed by divisions and is then discussed at the strategic performance reviews. The medical director attends the strategic performance reviews and then consolidates the review and reports to the clinical governance committee.

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The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NSS' approach to performance management was being monitored throughout the organisation.

### **oĒĪãĒĪ ããÖ=**

As NSS has not demonstrated that it is monitoring its approach to performance management, there is not yet a process in place to undertake a review.

**Information Governance**

The NHS Board is implementing its information governance systems, policies and procedures across the organisation.

**Information Governance**

NSS has a well-established information governance steering group which reports to the executive management team and the clinical governance committee. Information is disseminated through the organisation by divisional leads, chairs of the Caldicott guardians' forum, data protection, freedom of information and IM&T security groups. Those divisions that process patient identifiable data have a Caldicott guardian who is a member of the NSS Caldicott committee.

The NSS information governance framework was developed in consultation with all divisions. The framework is based on the NHSScotland information governance project brief and a risk assessment of NSS preparedness relating to information governance carried out in October 2004. The finalised framework was due to be presented to the clinical governance committee and NSS Board for approval in December 2006.

NSS' information governance steering group is made up of subject topic experts and those responsible at divisional level for information governance. The remit of the group is to build a consistent and cohesive approach to information governance across the organisation. The information governance steering group reports to the executive management team and to the clinical governance committee. The clinical governance committee provides assurance to the Board on the effectiveness of the information governance framework through audit exercises.

**Information Security**

NSS has a wide range of systems and processes to guarantee the confidentiality and security of personal information. At induction, all staff receive training on the principles of data protection, confidentiality and information security. The review team noted that a challenge to the organisation is the harmonisation of information governance throughout the organisation, for example confidentiality processes. A small group of staff are based off-site and unable to access web facilities, therefore, an induction CD has been developed which includes a section on information governance, and has been issued to all staff working in NSS.

Ongoing training is also provided at a divisional level and via the corporate portal. NSS has funded the development of an information governance specialist library which is accessible to all NHSScotland staff via the eLibrary. A training package explaining the key considerations in data protection, confidentiality and security that affect staff's daily work was also being rolled out to all divisions. Each division also has its own confidentiality guidelines which staff receive in their induction pack. Staff are required to confirm by signature that they have read these prior to commencing employment. The information governance steering group have agreed that the organisation should pursue the harmonisation of the confidentiality rules.

Access and authorisation to systems and records management processes are also in place across the organisation. NSS has an outline incident report scheme, however not all divisions use this as they use a paper-based process.

Personal information dealt with by NSS is handled in 'red zones' which are secure areas for the processing of confidential and sensitive data. Amber zones are for less sensitive data and green areas are those where no processing takes place.

Divisions within NSS have produced a range of public information leaflets (available in hard copy and on the website). Divisions also use NHSScotland public information leaflets to inform stakeholders about how their personal information is used. Stakeholders are also informed of their rights by telephone and in writing when requesting information under the Freedom of Information or Data Protection Acts. Members of the public who wish to access data held by NSS are asked, where possible, to complete NSS' subject access request form.

### **Information Governance**

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that NSS' approach to information governance was being monitored throughout the organisation.

### **Information Governance Review**

As NSS has not demonstrated that it is monitoring its approach to information governance, there is not yet a process in place to undertake a review.

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bafm equality and diversity information project=  
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kpa National Services Division  
= kpp NHS National Services Scotland  
= I ep^` occupational health and safety committee  
= mam personal development plan  
= mcmf patient focus and public involvement  
mfk partnership information network  
= mpa practitioner services department  
= pbea Scottish Executive Health Department  
= pk\_qp Scottish National Blood Transfusion Service

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The review visit to NHS National Services Scotland was conducted on 20 December 2006.

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Associate Medical Director, NHS Grampian
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Non Executive Director, NHS Highland
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Clinical Governance Co-ordinator, NHS Grampian
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Public Partner, Tayside
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Finance and Performance Management Director, The State Hospital's Board for Scotland
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Nursing Director, NHS Forth Valley
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Team Manager
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Project Officer
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Project Administrator
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Performance Analyst

During the visit, members of the review team met with Board-level, strategic and operational staff.

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