NHS
Quality Improvement Scotland

The State Hospitals Board for Scotland

Local Report ~ June 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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ISBN 1-84404-424-6

First published June 2007

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1 Setting the scene

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.

About this report

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 **The State Hospitals Board for Scotland**. This review visit took place on **18 January 2007**, and details of the visit, including membership of the review team, can be found in Appendix 2.

1.1 How the standards were developed

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.

1.2 How the review process works

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).

Self-assessment by NHS Boards

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.

Pre-visit analysis

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.

External peer review

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.

Performance assessment statements

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.

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 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.

1.3 Reports

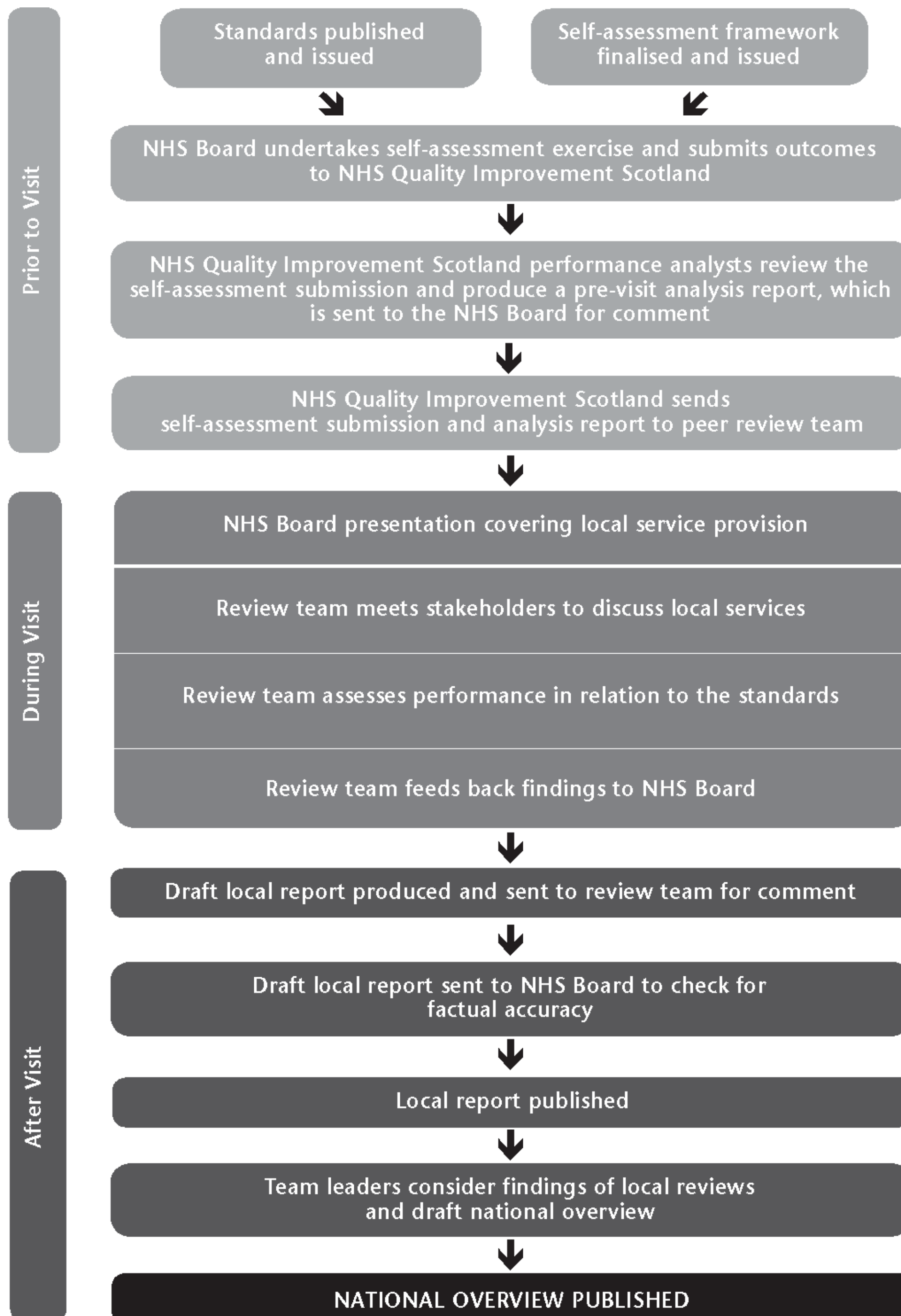
After each review visit, NHS QIS staff, with input as appropriate draft a local report detailing the findings of the review team. This draft report is sent to the review team for comment, and then to the NHS Board to check for factual accuracy. The local report will then be published and made available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

The review process



2 Summary of findings

2.1 Overview of local service provision

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

Local NHS system and services

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

Further information about The State Hospitals Board for Scotland can be accessed via its website (www.tsh.scot.nhs.uk).

2.2 Summary of findings against the standards

A summary of the findings from the review is presented in this section. A detailed description of performance against the standards/criteria is included in Section 3.

Standard 1 – Safe and effective care and services

Overall position statement:

The NHS Board is implementing its policies, strategies, systems and processes to control risk, continually monitor care and services, and work in partnership with staff, patients and members of the public.

The State Hospitals Board for Scotland recognises the high-risk environment in which it operates and has well-established risk management systems and processes in place which reflect this. Risk management is integrated throughout the hospital hierarchy and there is evidence of a partnership approach to risk management.

Comprehensive emergency planning arrangements are in place which reflect the potentially serious nature of emergency situations which could arise within the State Hospital site. These are rigorously tested, monitored and reviewed on a cyclical basis. However, business continuity planning is yet to be fully implemented.

A programme of clinical effectiveness activity is well developed within The State Hospital and there is a demonstrable commitment to continually improving the quality of care and service delivery.

Standard 2 – The health, wellbeing and care experience

Overall position statement:

The NHS Board is monitoring the implementation of its policies, strategies, processes and procedures to provide services that take into account individual needs, preferences and choices.

Systems and processes are in place to ensure that the individual needs, preferences and choices of all patients within the State Hospital are taken into account throughout their care experience. Given the compulsory detention of patients within the State Hospital, a high level of autonomy and consideration of human rights is provided to patients. The views and rights of carers are also given high priority and innovative methods of enabling patient/carer involvement are practised.

The State Hospitals Board for Scotland has demonstrated its commitment to the equality and diversity agenda and is taking systematic steps towards ensuring that all of its functions and processes are equality and diversity impact assessed.

Communication between staff, patients and the pubic within the State Hospital is viewed as an essential component of patient care/service delivery and considerable emphasis is placed on enhancing communication methods between these different groups.

Standard 3 – Assurance and accountability

Overall position statement:

The NHS Board is monitoring the implementation of its policies, strategies, processes and procedures to promote public confidence about the safety and quality of the care and services it provides.

The clinical governance framework within the State Hospital is evolving in line with wider changes in management structures. Established processes for implementing and monitoring clinical governance are in place, although systematic reviewing processes are less well developed. Wider involvement and engagement of clinical staff in the clinical governance agenda has had a positive impact on progress towards achieving the organisation's clinical governance objectives.

Robust systems are in place to ensure that all staff operating have the necessary knowledge, skills and, where appropriate, professional qualifications to carry out their role competently and effectively.

Specific emphasis is placed on the public image of the State Hospital and the way it communicates with external stakeholders. This is guided by an external communications strategy and a substantial amount of work has been undertaken to forge relationships with specific groups including the press commission and patient/carer representatives.

Robust performance management arrangements are in place to monitor the daily operations within the State Hospital and these provide a wealth of data to demonstrate progress against the organisation's corporate objectives.

The State Hospitals Board for Scotland's information governance arrangements continue to be implemented under the auspices of the recently finalised information governance strategy.

3 Detailed findings against the standards

Standard Statement 1: Safe and effective care and services
Care and services are safe, effective, and evidence-based.

Overall position statement

The NHS Board is implementing its policies, strategies, systems and processes 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

Position statement: The NHS Board is monitoring implementation of its risk management policy, strategy, systems and processes across the organisation.

Development

Given the nature of business conducted at the State Hospital, risk management is a key priority at both strategic and operational levels. There is comprehensive documentary evidence of the organisation's risk management arrangements including: a detailed risk management strategy; scheme of delegation, which identifies risk management responsibilities; and a corporate risk register.

The recently reviewed and updated risk management strategy sets out the overarching risk management methodology, organisational arrangements for risk management, and performance and assurance processes. It is evident that an inclusive approach was undertaken during the revision of the strategy, with opportunities for staff and stakeholders to be involved in this process. It was also reported that risk management training is included in the staff induction programme and forms part of mandatory health and safety training.

The scheme of delegation clearly details accountability and responsibilities for risk management, including ownership of strategic risk management objectives which are explicitly linked to organisational objectives identified in the local delivery plan (LDP). The corporate risk register provides a detailed breakdown of the organisation's top
20 strategic risks, with corresponding controls and actions, and identifies the individual with responsibility for each identified risk.

A number of specific documents are in existence which underpin the risk management strategy. These include an incident reporting and investigation policy, health and safety policy and guidance on risk assessments. The recently upgraded DATIX risk monitoring system is also in place to record incidents, complaints, claims and risks.

Implementation

The State Hospitals Board for Scotland was able to provide evidence to demonstrate the implementation of its risk management framework. The DATIX system is in place in clinical areas to record incidents, complaints, claims and risks, and the Board

reported that all events that are categorised as significant are subject to critical incident review. The review team also noted the State Hospital's success in integrating different categories of risk, such as patient safety, health and safety and clinical, into one framework.

The hospital risk management team provides support for the risk management process including staff training, analysis of events and reporting trends. It was further reported that the national risk matrix has been adopted for the risk assessment process throughout the hospital. The Australian/New Zealand risk management standard is also in use, although the review team noted some discrepancy in how risks are defined, particularly in relation to serious incidents.

At senior management level, risks to achieving the organisation's corporate objectives are highlighted on the corporate risk register. Annual workshops are held to review and develop the risk register in line with corporate objectives. The risk register includes details of necessary actions to mitigate against the identified risks and progress in relation to these actions. The senior management team (SMT) meets quarterly as the risk and governance committee (RAG)to formally evaluate progress against the risk register and, on a less formal basis, as issues arise.

Monitoring

The organisational arrangements for monitoring risk management activity have recently been reviewed in line with a change in the general management structure within the State Hospital.

At Board level, assurance that risk management issues are being addressed is achieved through the committee structure whereby each of the statutory governance committees of the Board (audit, clinical governance and staff governance) are responsible for the management of relevant risks identified on the risk register. It was reported that given the nature of the majority of risks, these are assigned to the clinical governance committee (CGC), which includes risk management as a standing item on its agenda.

Systematic monitoring of progress against items identified on the risk register takes place at meetings of the relevant Board committee which in turn provide progress reports to the Board. The audit committee has responsibility for overseeing risk management processes and reporting systems, and is responsible for signing off the corporate risk register, scoring and action plan development. The hospital's risk management processes are also subject to internal audit in terms of their effectiveness.

At senior management level, strategic risk management is formally addressed on a quarterly basis by the RAG, which includes partnership representatives on its membership. The RAG provides progress reports directly to the audit committee and receives standing reports on all areas of risk management, including operational activity issues and performance against the LDP. It was also confirmed that risk management issues are frequently discussed at weekly SMT meetings as and when they arise.

The hospital management team (HMT) monitors risk management implementation and performance operationally and, in line with the new general management structure, feeds directly into the RAG. Other routes for the escalation of risks to

senior/Board level include various specialist groups and committees such as the health and safety committee.

At operational level, the DATIX risk management system is used to collate local risk information and is utilised to analyse risk trends, and to produce regular risk reports. The risk management team provides support for this process and has direct links with members of the HMT.

Information on the hospital's risk management processes and issues are circulated to front-line staff by means of the hospital news bulletin, intranet and staff training.

Reviewing

Given the relative infancy of the hospital's general management structure, and recent changes to arrangements for monitoring risk management processes within the State Hospital, the review team was not assured that the systematic review of the effectiveness of risk management is fully embedded across the organisation.

Although reporting and monitoring structures are in place, in certain cases there appears to be an absence of evidence to support verbal assurances that risk management issues are systematically reviewed and used to inform decision making at all levels of the organisation.

Core area: 1(b) Emergency and continuity planning

Position statement: The NHS Board is developing emergency and continuity planning systems.

Development

Comprehensive emergency planning arrangements are in place which reflect the serious nature of emergency incidents that have the potential to arise within the State Hospital environment. The review team had the opportunity to review the incident command team (ICT) manual during the review visit and was assured that the State Hospital has fully developed its arrangements in respect of emergency situations and has worked with other agencies in developing these arrangements.

Continuity plans are detailed in the State Hospital's business continuity planning framework, which sets out targets for completion of business continuity plans in three core areas. On assessment of these plans during the review visit, it was evident that these plans are still in the developmental stages and are yet to be fully implemented. The review team emphasised the importance of comprehensive business continuity plans, particularly in view of the relative remote location of the State Hospital site.

Implementation

The minutes of the contingency planning liaison group (CPLG), and the numerous emergency scenarios which are fully tested on an annual basis, provided evidence that emergency planning arrangements are being implemented throughout the organisation.

Although there was no evidence provided at he time of the review visit that business continuity plans had been implemented and tested. Although verbal assurances were provided that this would be addressed in the future.

Monitoring

There is evidence that robust assessment and evaluation of all emergency planning exercises is undertaken following testing. Each emergency planning exercise document includes action plans and learning points. The CPLG is a subcommittee of the HMT. The CPLG reports directly to the HMT and has responsibility for taking forward any emergency planning issues which can be escalated to the SMT and Board if necessary.

There is no evidence of monitoring of business continuity planning due to an absence of fully-developed business continuity plans.

Reviewing

The comprehensive emergency planning framework in place within the State Hospital ensures the full review of emergency planning procedures, including the identification of learning points following emergency planning exercises and the development of action plans.

At present there are no mechanisms in place for reviewing business continuity planning.

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

Position statement: The NHS Board is monitoring the implementation of its co-ordinated programmes for clinical effectiveness and quality improvement across the organisation.

Development

The clinical effectiveness strategy sets out the aims and objectives of the clinical effectiveness department and describes how it will address national and local clinical effectiveness priorities. The clinical effectiveness work programme describes the operational detail of how these priorities will be addressed and outlines targets/outcomes, delivery mechanisms and levels of priority.

The clinical effectiveness strategy and work programme have been approved at senior management and Board levels and clearly link to the clinical governance strategy, which in turn draws from the organisational objectives identified in the LDP.

Implementation

There is a range of evidence to indicate that co-ordinated programmes for clinical effectiveness and quality improvement are being implemented across the organisation.

The standards assurance group has a key role in reviewing, disseminating and monitoring compliance with relevant standards and guidance throughout the organisation. In addition, there is a policies and procedures database, maintained by

the risk management team, which ensures that all local policies and procedures are recorded, assessed, implemented and reviewed.

Staff have access to a variety of resources to support clinical effectiveness activity including clinical effectiveness induction training, mastering clinical audit course and integrated care pathway (ICP) training. The clinical effectiveness department can also provide individual support for clinical effectiveness activity.

Evidence-based ICPs for admission, continuing care and inter-ward transfer are in use in all clinical areas and regular variance analysis is undertaken.

A number of examples were provided to illustrate the way in which patients, carers, the public and staff are involved in the hospital's clinical effectiveness/clinical improvement processes. The review team considered that the ward community meetings, patient partnership group and the carers reference group were worthy of note, and was impressed with the reported levels of engagement with patients and carers. This was considered to be particularly important in view of the average length of stay of patients within the State Hospital. The review team also received reports of the positive impact that multidisciplinary team behavioural standards have had on team working within the organisation.

The four 'Cs' report which summarises complaints and concerns, comments and compliments raised throughout the State Hospital was also viewed as a useful resource for monitoring the effectiveness of the services provided.

Monitoring

The LDP, which links explicitly to the clinical effectiveness strategy and work programme, incorporates key performance indicators to demonstrate tangible targets for continuous improvement in patient care and outcomes.

Monitoring of locally-developed targets demonstrates improvements in the physical health of the hospital population and work is ongoing towards developing measurable targets for improvements in mental health.

Comprehensive ICP variance analysis is carried out which has resulted in a number of changes in practice to improve patient care and outcomes.

Reviewing

A number of examples were cited as evidence that the review of clinical effectiveness programmes is being undertaken, however, the review team was not assured that the systematic review of clinical effectiveness programmes was being undertaken in all areas of the organisation.

Standard Statement 2: The health, wellbeing and care experience

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 position statement

The NHS Board is monitoring the implementation of its policies, strategies, processes and procedures to provide services that take into account individual needs, preferences and choices.

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

Position statement: The NHS Board is monitoring implementation of its policy and partnership approach to access, referral, treatment and discharge across the organisation.

Development

Policies for access, referral, treatment and discharge are well developed within the State Hospital.

There are well-evidenced examples of a partnership approach to care and the review team was impressed with the level of autonomy and exercise of rights afforded to patients, given their compulsory detainment within the State Hospital.

Implementation

Well-established ICPs for key patient-care processes including admission, continuing care and inter-ward transfer, are in use in all clinical areas. Individual treatment plans and nursing care plans, derived from the ICPs, are also in place. Discharge planning is carried out according to the care programme approach (CPA). There was a general acknowledgement of the complexities involved in discharging patients from the State Hospital which increases the need to communicate and engage effectively with all stakeholders involved in the process. The review team was pleased to note that all patients within the State Hospital have a named social worker, from their own NHS Board area, who plays an active role in the discharge process.

Illustrations of the transition from a custodial approach to a more therapeutic model of care were provided which served as further evidence of taking individual needs, preference and choices into account. This positive change in the culture within The State Hospitals Board for Scotland set the tone throughout the peer review visit. All patients are assigned a key worker on admission to the hospital. The key worker takes a particular interest in their treatment and care, and is seen as crucial to the partnership approach.

The views and needs of carers are seen as pivotal to the delivery of patient-centred services and a number of avenues are open to carers to express their views and assess their needs. Monthly carers meetings are held and a database of carers is kept to enable the effective circulation of information for carers.

While patient and carer involvement is certainly viewed as an important facet of the patient care experience within the State Hospital, there was recognition of the difficulties and complexities of ensuring that this particular patient/carer group is adequately represented. Examples were cited, during the review visit, of attempts to involve patients/carers, however, it was reported that response rates were often low and that the same individuals volunteered to represent the patient/carer group at different forums. It was further noted that the carer policy and carer action plan, provided as additional evidence, did not make specific reference to plans for monitoring the levels of carer involvement. This was acknowledged and the Board reported that there are plans to undertake a detailed patient and carer survey in the near future.

Several sources of information are available to patients, carers and the public about care and service provision. The State Hospital representatives emphasised that face-to-face verbal communication is the most important and effective mode of information delivery and that the role of the patient's key worker is particularly important in this respect. Other examples of information provided were in written format, however, it was confirmed that alternative formats could be made available if required, including audio versions and alternative languages. Translation and interpretation services are also available where required.

The views of patients and carers are also sought in relation to the quality and relevance of information provision. The patient partnership group, which includes patient representatives from all ward areas, meets on a regular basis and is used to seek patient views on such issues. Similarly, the carers' reference group is used to access the views of carers.

Monitoring

Monitoring of access, referral, treatment and discharge appears to be well established throughout the organisation. Weekly multidisciplinary team meetings are held to discuss all referrals and it is reported that the tighter application of referral policies, developed in consultation with the forensic care network, has resulted in a reduction in the number of inappropriate admissions to the hospital. The pattern of referrals and discharges to and from the hospital is closely monitored and details of all patient activity are reported to the CGC as a standing agenda item. All discharges from the State Hospital follow the CPA involving all relevant stakeholders in the discharge planning process. The CPA is rigorously monitored in terms of its effectiveness and benchmarking with other high security hospitals is also undertaken.

At a clinical level, the universal use of ICPs allows continuous variance analysis to take place which enables prompt identification of variance trends and, in turn, allows measures to address negative variances to be implemented. Examples of how ICP variance analysis has been used to make improvements in care were provided during the review visit. It was further reported that monitoring of treatment plans is ongoing to identify areas which are not being adequately completed by staff. Plans are also in place to develop key performance indicators for patient care processes, which will be built into the local delivery plan (LDP) monitoring framework.

Reviewing

It is clear that the arrangements for access, referral, treatment and discharge are well established, monitored and reviewed within the State Hospital. Examples were provided of how changes have been made to care processes as a result of the monitoring and review cycle. However, the challenge remains to ensure that this same level of assurance is applied to the patient focus public involvement (PFPI) agenda.

Core area: 2(b) Equality and diversity

Position statement: The NHS Board is implementing its equality and diversity policy in accordance with legislation, national guidance and best practice across the organisation.

Development

The State Hospitals Board for Scotland's PFPI strategy sets out its commitment to ensuring that all policies and functions are impact assessed in terms of equality and diversity. The PFPI steering group is ultimately responsibility for the delivery of the PFPI strategy and delegates authority to the equality, diversity and rights group (EDRG) to take forward equality and diversity issues within the State Hospital. The EDRG reports to the HMT via the PFPI steering group.

In addition, the independent patient advocacy service also has a role in ensuring that the equality and diversity rights of patients are addressed. The review team noted the independent management group which oversees the advocacy contract. The prominent profile of advocacy services within the State Hospital and the high level of patient uptake of the advocacy service was also worthy of note.

Systems are also in place to identify, assess and respond to the needs of groups and individuals who have particular needs or preferences. The delivery of patient care is governed by ICPs, from which individualised patient treatment plans are developed. The PFPI steering group and carers reference group also play a role in ensuring that individual needs and preferences are taken into account.

Implementation

The main vehicle for ensuring the implementation of the equality and diversity element of the PFPI strategy is the equality and diversity impact assessment toolkit, incorporating the rapid impact checklist. It was reported that all new policies are impact assessed prior to approval and that retrospective assessments are also being undertaken.

All hospital staff receive equality and diversity training as part of the induction process and mandatory training updates. Approximately 20 members of hospital staff have been specifically trained to carry out rapid impact assessments.

Monitoring

The EDRG has a specific remit for monitoring and reviewing the implementation of the rapid impact assessment tool. The EDRG reports to the HMT via the PFPI steering group. The Board receives assurance on equality and diversity matters

through the SMT who in turn receive information on the operational aspects of its equality and diversity strategy from the HMT.

Reviewing

It is evident that the State Hospital is committed to the principles of equality and diversity and has adopted a systematic approach to monitoring its functions and policies in terms of equality and diversity issues. However, there was limited evidence to provide assurance that the systematic review of equality and diversity issues is taking place across the organisation.

Core area: 2(c) Communication

Position statement: The NHS Board is monitoring its policies, strategies and procedures for improving the way that staff communicate and engage with each other, patients and the public across the organisation.

Development

The State Hospital's internal communications strategy focuses on staff communication and sets out the aims, objectives, communication mechanisms, roles and responsibilities, other communication channels, and methods of measurement in terms of internal communication. The strategy was developed by the communications manager and reviewed by the partnership forum prior to final approval by the staff governance committee (SGC).

Implementation

The relatively small numbers of staff working within The State Hospitals Board for Scotland and the close geographical proximity of the hospital departments helps break down some of the usual barriers to internal communication. The staff interviewed during the review visit reported that a very obvious physical presence of management within the clinical areas and a relatively stable workforce in the main staff groups also acts as an aid to good internal communication.

Nevertheless, a number of mechanisms are in place to enhance and formalise face-to-face exchanges of information. The staff bulletin and intranet are reported to be the key internal communication tools within the organisation, however, there was recognition of the need to further develop the intranet.

Monitoring

The results of the national staff survey are the main mechanism used to monitor the effectiveness of the internal communications strategy. In addition, the staff governance audit and completion of the self-assessment for the NHS QIS clinical governance and risk management review have provided valuable feedback on internal communication processes within the State Hospital. In particular, the evaluation of initiatives set out in the internal communications strategy has led to the discontinuation of the core brief as an effective method of staff communication.

Reviewing

Although it was possible to identify some changes to internal communications processes as a result of the monitoring and review of communications mechanisms, the Board was unable to demonstrate that the systematic review of internal communications was taking place across the organisation.

Standard Statement 3: Assurance and accountability

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

Overall position statement

The NHS Board is monitoring the implementation of its policies, strategies, processes and procedures 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

Position statement: The NHS Board is monitoring implementation of its policy and strategy to co-ordinate clinical governance and quality assurance arrangements across the organisation.

Development

The State Hospitals Board for Scotland's clinical governance strategy sets out the clinical governance work plan and details the strategic aims and responsibilities and accountabilities in terms of clinical governance. The chief executive holds ultimate accountability for clinical governance within the organisation while the medical director is the executive lead for clinical governance.

Implementation

Leadership for the operational implementation of clinical governance is provided by named directors who are accountable to the medical director. Other directors are also designated leads for certain elements of clinical governance dependent on their expertise. Each lead director has a responsibility to update the Board's CGC on progress against their designated area of clinical governance.

The HMT also has a responsibility for monitoring the implementation of the clinical governance strategy and progress against clinical governance objectives is a standing item on the HMT meeting agenda.

Support for the operational implementation of clinical governance is provided by the clinical effectiveness department and the risk management team.

The review team was encouraged that there has been widespread recognition of the need to involve and engage clinical teams in clinical governance activity and it was clear that widespread consultation with all staff had been undertaken as part of the restructuring process. Representatives of the Board acknowledged that clinical governance objectives could not be achieved without the input from staff in clinical areas.

There are also mechanisms in place to ensure that patients, carers and the public are informed, involved, consulted and able to provide feedback when the Board is planning, monitoring and improving services. This was seen to be particularly pertinent in relation to the plans to redevelop the State Hospital site. It was reported

that re-development subgroups, of the patient partnership and carers reference groups, have been formed to ensure engagement of patients and carers in the redesign process.

The review team also noted the rigorous research framework which is in place within the State Hospital. A significant volume of research is undertaken within the State Hospital and an annual clinical governance and research conference is held to showcase this important work and enable the dissemination of best practice.

Monitoring

Along with other functions within The State Hospitals Board for Scotland, the organisational framework for monitoring clinical governance arrangements has recently undergone a restructuring process in line with a change in the senior management and general management structure. It was reported that these structural changes have strengthened and consolidated the existing clinical governance monitoring arrangements which are well established within the State Hospital. However, the review team considered that there is a need to continue to embed the new clinical governance monitoring framework throughout the organisation and a need for further clarity with regards to which clinical governance issues are monitored through which channels.

The role of the CGC continues to be the receipt of high level assurance that clinical governance issues are being addressed throughout the organisation. It was reported that this assurance is achieved through reporting of progress against the targets set out in the clinical governance work plan. An annual clinical governance report is presented to the Board along with regular reporting from the various directors/subcommittees with responsibility for different strands of clinical governance activity.

It was further reported that the new structure has resulted in the devolution of accountability for clinical governance to designated lead directors within clinical areas, which has strengthened the role of clinical teams and their decision-making capacity in terms of clinical governance.

The review team was encouraged by reports during the review visit that the restructuring has had a positive impact on clinical governance issues and, in turn, on patient care.

Reviewing

Although it was evident that the underlying structures to support clinical governance are well established, the review team considered that the reviewing arrangements are still very much in the early stages.

Core area: 3(b) Fitness to practice

Position statement: The NHS Board is implementing its policies and procedures across the organisation that will ensure its workforce is fit to practice.

Development

A number of measures are in place to ensure that the workforce within The State Hospitals Board for Scotland is fit to practice. The recruitment and selection policy and guidelines ensure that recruitment and selection processes are rigorous and are in line with mandatory human resources (HR) guidance.

All staff undergo enhanced security checks prior to commencing employment within the State Hospital and there is ongoing monitoring of professional registration.

Implementation

The State Hospital's HR department is responsible for ensuring that the recruitment and selection policy and guidelines are enforced and it was reported that a member of HR staff is present on interview panels of all potential members of the workforce.

The HR department also maintains a registration and accreditation database to ensure that all staff renew and update these at the required intervals.

There is also a clear commitment to the continued professional development of staff within the State Hospital. It was reported that the vast majority of staff have personal development plans which identify their professional development needs.

The learning and development directorate has recently undergone a process of restructuring to provide additional focus and support for training and development. The Board reported that a review of senior nursing roles has also enhanced the co-ordination of training and development issues.

The review team noted the clinical supervision pilot exercise which is trialling clinical supervision for nurses within some clinical areas. It was also reported that clinical supervision is in place for allied health professionals and medical staff. The team recognised the challenges of rolling out a comprehensive clinical supervision framework for all nursing staff. However, it considered that this is an invaluable resource for all staff and it is important that it is made universally available across the organisation.

Monitoring

Although there is evidence that some monitoring of fitness to practice issues is being undertaken, the Board did not demonstrate that routine monitoring is taking place across the organisation.

At the time of the visit, there were no formal mechanisms in place to monitor and review compliance with the recruitment and selection policy and guidelines.

The SGC is the main forum for monitoring staff governance issues including those which impact on fitness to practice. Key performance indicators (KPIs) for recruitment and retention of staff are in place and these are standing items on the agenda at meetings of the SGC. The SGC reports directly to the CGC on staff governance issues.

Reviewing

The review team agreed that issues impacting on fitness to practice are not routinely reviewed as part of the continuous improvement process. However, the team was informed that a full review of the recruitment and selection policy and guidelines is scheduled in 2007.

Core area: 3(c) External communication

Position statement: The NHS Board is monitoring the implementation of its external communication strategy across the organisation.

Development

The requirement to have an external communications strategy for The State Hospitals Board for Scotland is viewed as particularly pertinent in view of the intense media interest in the hospital and its patients, and future plans to redevelop the site. The ability to communicate effectively is therefore viewed as fundamental to the daily operations of the organisation.

The external communications strategy sets out the organisation's current position in terms of external communications, outlines future aims and objectives, and describes how these will be achieved, evaluated and monitored.

Implementation

A range of evidence was presented to demonstrate progress towards the objectives identified in the external communications strategy. The review team noted the practice of holding the State Hospital Board meetings in different geographical regions of the country to promote accessibility for stakeholders.

Significant emphasis is also placed on developing effective methods for communicating with carers. The review team was impressed with the facilities provided within the recently-opened carers centre and reports of how this has greatly improved the experience of visitors to the hospital. It was, however, reported that the centre is not being utilised to its full potential, because of a small number of carers visiting the hospital.

Various publications specific to the State Hospital are produced in addition to a dedicated website.

The review team noted the steps that have been taken to develop a more positive relationship with the media and, in particular, the work with the press commission to develop standards on how mental health issues are reported.

Monitoring

A number of mechanisms are in place to monitor the effectiveness of the external communications strategy. These include monitoring the number of users accessing the State Hospital's website, including which pages are being accessed and which publications are viewed and/or downloaded. The review of comments and suggestions received from the public, patients and staff, culminated in the production of the four 'Cs' report. An evaluation of the translation/interpreting service has also been undertaken. It was further reported that the external communications strategy includes an action plan, which is regularly reviewed, to monitor progress against its objectives.

Reviewing

Although it was possible to identify some changes to the external communications strategy as a result of the review of communications mechanisms, the review team agreed that the systematic review of external communications was not taking place across the organisation.

Core area: 3(d) Performance management

Position statement: The NHS Board is monitoring the implementation of its performance management arrangements across the organisation.

Development

The organisation's performance management framework is outlined in the LDP. The plan describes the organisational structures and processes for performance management, along with the reporting mechanisms across the different managerial levels, and explains how linkages between these levels are maintained.

Given the relatively new management structures, it was apparent that performance management arrangements have recently been evaluated and reviewed. It was reported that the new arrangements are working well and that a clear delineation between strategic and operational issues has now been achieved.

Implementation

A systematic performance management structure is evidenced with clear lines of reporting on performance management issues from clinical/operational areas through the HMT to the SMT who provide assurance of performance management issues to the board through the CGC.

A range of information is gathered from numerous sources for performance management purposes. It was reported that indicators from the performance assessment framework (PAF) form the basis of the performance management system, although additional data is also collected in order to monitor progress against all the objectives identified in the LDP. The review team was particularly impressed with the four 'C's' report which is a summary of complaints and concerns, comments and compliments.

Monitoring

Day-to-day management systems are in place to capture information for monitoring progress against the objectives identified in the LDP and it was reported that as part

of the annual review process The State Hospitals Board for Scotland has been commended for its LDP monitoring framework. Where possible, performance indicators and targets are based on national indicators, although it was noted that there is a general lack of specific mental health indicators.

Outputs of the performance management systems are systematically reported throughout the organisational hierarchy from clinical/operational areas through to the CGC. It was noted that work is currently in progress to develop a single corporate performance report and consolidated performance reports for clinical teams.

Some benchmarking with other high security psychiatric hospitals has been undertaken as part of the annual review process. Particular areas of comparison have been sickness absence performance and admission rates. Benchmarking has also proved useful to support work on the business case for redevelopment of the hospital site.

Reviewing

It was reported that a project is currently being taken forward to review current performance management data systems in order to align them with the requirements of the LDP. This includes designing and implementing new data systems to address gaps between data requirements for the PAF and data requirements of the LDP.

The review team was encouraged that performance management systems are well established within the State Hospital and that there is a clear commitment to continuous improvement. However, at the time of the review visit, the relative infancy of the new management arrangements had not enabled the full review of performance management to be undertaken.

Core area: 3(e) Information governance

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

Development

The State Hospitals Board for Scotland's information governance framework was developed by the collective efforts of the information steering group, clinical records and data protection group, and freedom of information group. The framework was based on existing policies and strategies, including an information strategy, and has recently been ratified by the Board. It sets out the organisation's aims and objectives in relation to information governance.

The review team noted the rigorous approach to data confidentiality and security, and received assurance during the review visit that this crucial area of patient care is seen as paramount. It was further reported that a composite clinical records policy is currently under development.

The CGC has overall responsibility for overseeing the implementation of the information governance framework. At operational levels, several groups are involved in taking forward information governance issues including the information

steering group, freedom of information committee, and the clinical records and data protection group.

Implementation

At the time of the review visit, The State Hospitals Board for Scotland provided a range of examples to indicate that it is implementing its information governance systems, policies and procedures across the organisation. These include the implementation of the recently ratified information governance framework which is underpinned by a number of key documents such as an information strategy, an information and network security policy, a data protection policy, freedom of information policy, and procedures and information sharing protocols. It was further noted that a clinical records and non-clinical records policy are in draft formats.

There was an acknowledgement that given the relative infancy of some of these documents, in particular the recently finalised information governance framework, implementation of information governance was in the early stages at the time of the review visit.

Monitoring

There was evidence that some reporting and monitoring of the implementation of information governance was taking place in terms of progress reports to the CGC from the various operational management groups with information governance responsibilities. However, there was no evidence that information governance systems, policies and procedures are being systematically monitored across the organisation.

Reviewing

There was no evidence that information governance systems, policies and procedures are being systematically reviewed across the organisation.

Appendix 1 – Glossary of abbreviations

CGC	clinical governance committee
CNORIS	Clinical Negligence and Other Risks Indemnity Scheme
CPA	care programme approach
CPLG	contingency planning liaison group
EDRG	equality, diversity and rights group
HMT	hospital management team
HR	human resources
ICP	integrated care pathway
ICT	incident command team
KPI	key performance indicators
LDP	local delivery plan
NHS QIS	NHS Quality Improvement Scotland
PAF	performance assessment framework
PFPI	patient focus and public involvement
RAG	risk and governance committee
SEHD	Scottish Executive Health Department
SGC	staff governance committee
SMT	senior management team

Appendix 2 – Details of review visit

The review visit to The State Hospitals Board for Scotland was conducted on 18 January 2007.

Review team members

Dr Mike Winter (Team Leader)
Associate Medical Director, NHS Lothian

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Public Partner, Greater Glasgow

Ms Margaret C Duffy
Chief Operating Officer, NHS Forth Valley

Ms Jenny Ingram
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Ms Liz Macdonald
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Mrs Joanna McGregor
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Ms Marion McLoone
Divisional Quality & Effectiveness Manager, NHS Greater Glasgow and Clyde

Ms Maggie Simpson
Director of Nursing Single Delivery Unit, NHS Tayside

NHS Quality Improvement Scotland Staff

Ms Angela Balharrie
Project Officer

Ms Tracy Walker
Senior Project Officer

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

Appendix 3 – Timetable of review visits

Organisation reviewed	Visit date(s)
Golden Jubilee National Hospital	8 November 2006
NHS 24	17 August 2006
NHS Ayrshire & Arran	13 February 2007
NHS Borders	24 May 2006
NHS Dumfries & Galloway	8 June 2006
NHS Education for Scotland	5 December 2006
NHS Fife	1 March 2007
NHS Forth Valley	1 February 2007
NHS Grampian	6 July 2006
NHS Greater Glasgow and Clyde	27 September 2006
NHS Health Scotland	26 April 2007
NHS Highland	29 March 2007
NHS Lanarkshire	7 September 2006
NHS Lothian	17 October 2006
NHS National Services Scotland	20 December 2006
NHS Orkney	23 November 2006
NHS Shetland	10 May 2007
NHS Tayside	14 March 2007
NHS Western Isles	12 April 2007
Scottish Ambulance Service	15 June 2006
The State Hospitals Board for Scotland	18 January 2007

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