“Clinical governance is the defining heart and inspiration of quality in the NHS”

Aidan Halligan 2006

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**Executive Summary**

Clinical Governance is an umbrella term that covers a wide range of activities that ensure safe and effective healthcare.

These activities have been grouped under four elements:

- Patient and public involvement
- Clinical effectiveness and quality
- Staff training and accreditation
- Risk management and complaints

This strategy sets out the current model of clinical governance delivery in Shetland and describes the corporate objectives, which underpin the further development of the clinical governance infrastructure.

Each section is based around the core clinical governance activities, which include:

- Patient and public involvement
- Risk Management
- Clinical Effectiveness
- Staff Governance.

Strategic objectives and actions plans are detailed within this strategy with respect to the core activities described above.

Appendix B, sets out the key performance indicators for clinical governance for 2010-11. The Clinical Governance Co-ordinating Group will review the indicators annually.

The strategy also sets out the roles and responsibilities across the organisation for ensuring that clinical governance is embedded in every day practice both horizontally and vertically within the organisation. This can be found in section 5 and Appendix A, which outlines the terms of reference for the committee tasked with ensuring that clinical governance is supported at an operational level.
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Clinical Governance Strategy for 2010-13

1. Context

Clinical governance has been a statutory duty for every NHS body in Scotland since 1999. NHS Boards have a responsibility to ensure that quality and clinical effectiveness are driving decision-making about the provision, organisation and management of services.

Clinical governance is now recognised as a component in the accountability and improvement process that implements policy on all patient services. These processes can be used to help implement changes to the way teams deliver care and in the way services are organised. Clinical governance forms part of the overall corporate governance strategy, which also includes financial governance and staff governance.

The standards set out by NHS Quality Improvement Scotland in the Clinical Governance and Risk Management Standards; Achieving safe, effective, patient-focused care and services (2005), lay out a blueprint for service delivery and integrated clinical governance.

These standards are:

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<td>Standard Statement:</td>
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<td>Care and services are safe and</td>
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<td>effective and based on available</td>
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<td>evidence.</td>
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<th>STANDARD 2: The health, well-being and care experience</th>
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<tr>
<td>Standard Statement:</td>
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<tr>
<td>Care and services are provided in partnership with</td>
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<td>patients, carers and the public, treating them with</td>
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<td>dignity and respect at all times, and taking into</td>
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<td>account individual needs, preferences and choices.</td>
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<th>STANDARD 3: Assurance and accountability</th>
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<tr>
<td>Standard Statement:</td>
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<tr>
<td>NHSScotland is assured and the public is</td>
</tr>
<tr>
<td>confident about the safety and quality of</td>
</tr>
<tr>
<td>NHS services.</td>
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These standards are mandatory. This strategy has been developed to ensure that all the components of clinical governance are assessed for efficiency and effectiveness, and are underpinned by a culture of continuous improvement. Specifically, following the 2007 NHS QIS peer-review process, an improvement plan was developed to increase performance against the standards, and this continues to be updated during the lifetime of the current Clinical Governance Strategy.
The core areas identified in the Clinical Governance and Risk Management standards are:

- Risk Management
- Emergency and Continuity Planning
- Clinical Effectiveness and Quality Improvement
- Access, Referral, Treatment and Discharge
- Equality and Diversity
- Clinical Governance and Quality Assurance
- Fitness to practice
- Communication (internal and external)
- Performance Management
- Information Governance

2. Introduction

This strategy describes the framework that will be used by Shetland NHS Board (the Board) to deliver high quality, patient centred, safe services for the people of Shetland over the next three years.

In particular, the strategy sets out key objectives for the future development of the model for clinical governance, risk management and performance management between 2010-2013.

It builds on the original NHS Shetland Clinical Governance Strategy developed in 2007 and the achievements of the last 3 years. It has been reviewed through consultation with key stakeholders and is designed to provide a framework for development over the next three years. It is intended to be a living document and will continue to evolve as NHS Shetland develops in response to new initiatives and lessons learnt from its implementation.

The NHS QIS Clinical Governance and Risk Management (CGRM) Standards set out the Standards for Clinical Governance and Risk Management within the NHS in Scotland. Key to successful achievement of these standards is the embedding of processes for continuous quality improvement (CQI) throughout the organisation.

In an initial review against these standards NHS Shetland received an overall score of 7 out of 12. As part of the current Government HEAT targets we are challenged to improve our performance against these standards to a score of 9 by the follow up review in April 2010.

Other external drivers, which have influenced the development of this strategy and objectives, include:

- The Scottish Government Better Health Better Care Action Plan
- The Scottish Government Patient Experience Programme, Better Together
- The Scottish Patient Safety Programme
- The Institute for Healthcare Improvement’s (IHI) model for improvement
3. Philosophy

Clinical governance is core to the safe delivery of all processes, systems and services in the NHS. The Board is committed to developing and refining the clinical governance framework/model, which is in place and the underlying principles that ensure services are patient focussed, safe, clinically effective, and delivered in partnership with other health and social care agencies.

The organisational philosophy is centred on providing safe services through the development of a robust clinical governance framework, which promotes:

- Confidence and trust (staff and public)
- Leadership
- Continuous development and improvement
- Staff accountability
- Partnership working
- Patient focus and community engagement
- Training and development

The next section describes how we have embedded our organisational philosophy and the integrated approach in place for clinical governance systems, which supports the delivery of these principles.

4. Integrated clinical governance at NHS Shetland

Clinical Governance is an umbrella term that covers a wide range of activities that ensure safe and effective healthcare.

These activities have been grouped under four elements:

- Patient and public involvement
- Clinical effectiveness and quality
- Staff training and accreditation
- Risk management and complaints

These elements are interrelated and the illustration below shows the way in which they work together to promote continuous improvement.

Clinical governance framework
This visual representation of a clinical governance model has been found to be a very effective way of communicating the principles and elements of clinical governance to staff at all levels. The statements (e.g. “getting it right”) have been developed to help staff ground the concept of clinical governance into everyday practice. The following narrative explains in more detail, the key components of each ‘dimension’ and the structures in place, which support the clinical governance framework in Shetland. Each section also includes further detail around the strategic objectives and actions set around the specific areas for 2010-13 and beyond.

“Able to do the job well”

4.1 Staff Training and Accreditation

This includes the following components:

- Peer review
- Objective setting
- Clinical supervision and mentoring
- Continuous professional development
- Personal performance and development
- Identifying poor performance
- Scottish health at work
- Continuing medical education
- Professional accreditation and regulation

This dimension is about supporting staff to develop and maintain appropriate skills and competencies to perform their jobs safely and effectively. These activities are supported by:

- Competency frameworks
- Workforce planning strategy
- Staff governance strategies (e.g. staff development programme and human resources policies).
- Regular corporate updates (e.g. induction programmes, mandatory training)
- Appraisal systems

4.1a Strategic approach and corporate actions

The Board’s strategic and operational approach to delivering comprehensive training and education for all staff is outlined in more detail in its Organisational Development Strategy and Implementation Plan. In addition to this we have Staff Personal Planning and Review Procedures and a Board wide Training Plan. The core objectives of the agenda are summarised in the section below:

*Opportunities for all.*

- All staff will have equitable opportunity to develop their skills and knowledge appropriate to their role within the organisation.
- Training will be provided through local programmes and external providers. This will include generic courses offered and co-ordinated by the Staff Development
Department and specific training provided by the governance support team in respect of risk assessment, incident reporting and clinical effectiveness.

- Clinical Governance Seminars will be delivered by the Clinical Governance Support Team (CGST) to provide learning opportunities for all Board staff. Externally provided learning opportunities will also be provided as appropriate.

**Measuring and supporting development of staff performance.**

- As part of the process for implementing the Knowledge and Skills Framework (KSF), all staff have updated job descriptions.
- KSF job outlines have also been developed which set out the knowledge and skills levels required for all posts.
- A range of training opportunities have been put in place to support staff with the completion of new job description formats. KSF outline development and personal development plans (PDPs). This includes orientation sessions for the development of electronic KSF outlines and PDPs.
- The Staff Development Department has put in place a comprehensive programme of learning events and courses to support staff with identified training needs.
- The Staff Development Department also monitors training packages in terms of user applicability through the collation of evaluation form feedback and course uptake rates.

“Able to learn”

**4.2 Risk Management and Complaints**

This includes the following components:

Complaints management
Managing risk and implementing controls
Significant event analysis
Procedure and guidelines
Performance management reporting and scrutiny

This dimension describes some of the ways in which the organisation gathers feedback on the effectiveness of services and mechanisms for reducing risks. These activities are supported by:

- A clear risk assessment framework
- Ownership of the risk management framework at a senior level
- Risk Management and Health & Safety Team provide resources to support risk/incident systems
- A programme of leadership walkarounds facilitated by senior managers which includes non executive and lay representation to strengthen accountability and assurance roles
- Integrated service improvement and clinical governance functions
- A clear process for reviewing guidelines and best practice statements
4.2a Strategic approach and corporate actions

The strategic and operational approach to delivering risk management is outlined in more detail in its Risk Management Strategy. The core objectives of this document are summarised in the section below:

- **Development of Risk Management.** The Board will continue to develop and refine risk management processes which integrate clinical and non-clinical aspects of risk management where this is appropriate, thus allowing for a more consistent and joined up approach to the delivery of safe and effective care. An organisation wide approach to the implementation of risk management will be encouraged and is considered the business of all staff at all levels within the organisation.

- **Fair and Open Culture.** The Board aims to fully establish a fair and open culture. Such a culture promotes responsibility and accountability amongst staff. It acknowledges that whilst errors occur, only those that are intentional, knowing, reckless or negligent or subsequently concealed require a punitive response. Staff are encouraged to report incidents and discuss at a team level. Incidents should then be used to formulate plans to reduce the risk of them re-occurring.

- **Responsibilities for Risk Management.** Line and service managers should be aware of their specific responsibilities as noted in the Board ‘Risk Management Strategy’ and ‘Incident Reporting Procedure’.

- **Complaints Management.** The Board is committed to listening carefully and responding appropriately to complaints ensuring that systems are in place to ensure lessons are learned. Systems are in place for recognising when things go wrong, investigating why problems occur and instituting changes where appropriate. The Board’s complaints procedures follow national guidance and are updated appropriately. In addition to this, a complaints handling procedure also forms part of the primary care contracts. Training on handling complaints is held regularly and written guidance is available for all staff.

- **Delivery of Risk Management.** The co-ordination, development, refinement and monitoring of risk management and incident reporting processes and outcomes is the responsibility of the Clinical Governance Co-ordinating Group.

- **Electronic Support for Risk Management.** The Board’s risk management process is underpinned by the use of specifically developed electronic systems (i.e. DATIX), which allow for efficient and effective management of incident reporting and the risk register.

- Training and educational support is given to all staff and at mandatory refresher days.
“Listening to people”

4.3 Patient and Public Involvement

This includes the following components:

Patient involvement
Communication and consultation
Engaging with communities
Providing information (corporately and as part of the provision of services)
Patient feedback
Working with health partners (e.g. the local authority)

This dimension is about recognising that services must to be seamless and patient centred. The patient experience includes contact with a wide range of services (not just the clinical episode) and this element focuses on the mechanisms in place to ensure that all steps in the patient journey are timely, appropriate and easy to access.

These activities are supported by:

- Patient Focus Public Involvement (PFPI) Strategy
- Volunteering services (e.g. volunteering policy)
- Community Health and Care Partnership (CHCP) action plan (e.g. including the Carer’s Strategy)
- Equality and diversity strategies (e.g. spiritual care, translation services)
- Patient surveys (e.g. through GP Practices)
- Public Partnership Forums
- Comments and suggestions scheme

4.3a Strategic approach and corporate actions

The Board’s strategic and operational approach to delivering PFPI is outlined in more detail in its Patient Focus Public Involvement Strategy and associated policies and procedures. The core objectives of the PFPI agenda are summarised in the section below:

- The Board has established ‘The Patient Focus Public Involvement Steering Group’ which co-ordinates initiatives to help deliver the principles of PFPI and develop the required policy and procedures to help embed these principles across the organisation. Members of the public will also be involved in the strategic development and redesign groups.

- The Board has established “NHS Shetland 100”. This forum invites members of the public to regularly comment on and discuss how clinical services are delivered in Shetland and how improvements might be made to these services and their delivery. Working within the umbrella of “Better Together” the comments and views equate to real changes and improvements for patients.
Involving Staff.

- Individual departments are encouraged to seek user and carer representation when reviewing their services.

- Patient and public views are actively sought through a comments and suggestions scheme as well as other initiatives.

- Those responsible for producing Policy, Procedure and Guidelines are encouraged to consider the principles of PFPI and include them as are appropriate to the document.

- Those responsible for producing Policy, Procedures and Guidelines are required to ensure that the policy development process is in keeping with equality and diversity principles and legislation, and that an Equality and Diversity Impact Assessment (EQIA) is an integral part of strategy and policy development.

- Training and educational support is given to all staff and at induction and mandatory refresher days.

- The Wider Agenda: The Board’s approach to PFPI also recognises the wider agenda of ‘Fair for all’ and links closely with this. Putting people and patients first is at the heart of the Board’s approach to clinical governance.

“Getting it right”

4.4 Clinical Effectiveness and Quality

This includes the following components:

- Clinical guidelines
- Clinical audit (including Joanne Briggs Institute resources)
- External monitoring (e.g. NHS Quality Improvement Scotland; Quality outcomes Framework; External audit studies; payment verification)
- Continuous Quality Improvement programmes (e.g. Scottish Patient Safety Programme, nursing CQI programme)
- Research and development
- Care pathways
- Information governance (IG)
- Quality assurance frameworks (e.g. underpinning clinical networks)

This dimension describes the ways in which we ensure as an organisation, that our procedures, policies and services are fit for purpose and underpinned by best evidence/current research.

These activities are supported by:

- External reviews (e.g. Audit Scotland)
- National standards implementation (e.g. SIGN guidelines)
Key performance indicators (in local strategies and against the national NHS performance framework)
Service improvement programmes (e.g. 18 week referral to treatment standard programme)
Clinical pathways development (e.g. mental health integrated care pathway programme supported by NHS QIS)
Clinical networks (e.g. long term conditions managed clinical networks)
Informatics and information governance
Clinical governance workshops and multi-disciplinary meetings
National audits (e.g. the review of surgical mortality, stroke care etc)
Multi-disciplinary audit programme

4.4a Strategic approach and corporate actions

Clinical Effectiveness. The Board’s strategic and operational approach to delivering clinical effectiveness is outlined below:

- **Standards.** The clinical governance structure and arrangements that are in place aim to support continuous improvement in the standards expected of clinical care in terms of structure, process, outcome and knowledge. Services throughout the Board aim to meet when appropriate, and exceed where possible, the standards defined by Quality Improvement Scotland (QIS). These standards are implemented consistently in order to minimise unacceptable variations in service delivery.

- **Clinical Audit.** Clinical Audit forms part of professional practice. All healthcare professionals are expected to participate in audit activity and are empowered to positively influence the quality of care delivered.

- **Clinical Guidelines.** Guidelines to direct clinical care are produced by a variety of bodies and professional organisations. The Board recognises the value of Scottish Intercollegiate Guidelines Network (SIGN) Guidelines and all Healthcare Practitioners are encouraged to use SIGN guidelines as appropriate to their area of practice. New SIGN guidelines are brought to the Clinical Governance Co-ordinating Group. The Board also supports, where appropriate, the development of local guidelines. Clinical staff are also encouraged to use guidelines from their professional bodies and other appropriate sources to inform their practice. Such as the Scottish Clinical Information Management in Practice (SCIMP) guidelines which are used in Primary Care.

- **Evidence Based Care / Practice** The Board is committed to the provision of evidence based care / practice. Standards, clinical audit and clinical guidelines all support staff in the provision of delivering evidence-based care. Access to the Internet, electronic databases and e-learning support the delivery of evidence based care.

- **Research.** The size of the Board coupled with limited resources does not allow a comprehensive clinical research programme to be undertaken. However where it is appropriate for projects to take place these will be encouraged and supported. Arrangements are in place with NHS Grampian to provide support and advice through their links with the Clinical Governance Co-ordinator. The Board’s practice is in line with national Research Governance Standards.
Quality management. To be most effective, and to support the delivery of the highest quality of care, the Board recognises clinical governance must be integrated with Staff, Financial and Corporate Governance as part of an integrated approach to delivering a high quality service. To that end, structures and process for delivering and evolving clinical governance are designed to complement this approach. Service improvement and continuous improvement methodologies are part of the integrated toolkit available and supported by clinical governance staff (e.g. process mapping, clinical audit, survey and patient experience feedback tools, evaluation cycles such as PDSA (plan, do, study, act) and patient flow analysis, benchmarking etc). As an example of this, the Scottish Patient Safety Programme includes a wide range of total quality management approaches to improve patient outcomes (i.e. audit, benchmarking, improvement cycles and lean principles) and this programme is facilitated by clinical governance personnel who are trained in a wide range of service improvement techniques.

Performance management. In order to both measure and drive performance across the organisation, the Board has put in place a performance management framework which has been developed to support the delivery of local and national targets set out in the NHS performance framework, which describes 30 HEAT targets and 33 HEAT key performance measures for health. Our Local Delivery Plan (LDP) sets out a delivery agreement between the Scottish Government Health Department (SGHD) and the Board, based on the key Ministerial targets.

The Local Delivery Plan reflects the HEAT Core Set - the key objectives, targets and measures that reflect Ministers' priorities for the Health portfolio.

The key objectives are as follows:
- Health Improvement for the people of Scotland - improving life expectancy and healthy life expectancy;
- Efficiency and Governance Improvements - continually improve the efficiency and effectiveness of the NHS;
- Access to Services - recognising patients' need for quicker and easier use of NHS services; and
- Treatment Appropriate to Individuals - ensure patients receive high quality services that meet their needs.

Progress against HEAT targets is published throughout the year by the SGHD and locally via performance reports to the Board.

The framework, which is described in the Performance Strategy, sets out the vision for improving outcomes for patients through the implementation of effective management systems and the development of an organisational culture, which embraces continuous service improvement. It also includes a high level plan setting the direction for further developing a high performance culture and systems to measure performance over the next three years. This agenda is inextricably linked to clinical effectiveness, improvement clinical outcomes, improving the experience for patients and organisational productivity and efficiency.

In addition to this, the Board’s risk management strategy sets out the assurance processes to ensure that risks are identified and appropriately managed. Risks must be linked to
objectives and performance targets indicated in the LDP, so that informed decisions can be made with regards to prioritisation of resource utilisation directed toward their management based on robust risk information.

The Boards Patient Focus Public Involvement Strategy provides the framework for involving people in the development of the LDP.

Information Governance and the delivery of Clinically Effective Services

The Board’s clinical governance strategy is complemented by the e-health plan, and Information Governance plan which supports the delivery of objectives and targets by ensuring that systems are in place to provide data validation/abstraction tools to allow information to be shared which inform clinical and managerial teams about current performance and outcomes (for example providing information to enable benchmarking exercises to be undertaken).

The e-health plan and Information Governance Policy also describe how the Board is taking forward the implementation of new technologies such as telehealthcare to improve patient pathways and access to services. An example of this is the implementation of a telehealthcare service for patients requiring ear, nose and throat diagnostics.

The core objectives of the clinical governance strategy with regards to information governance are summarised in the section below:

- **Use of information.** The Board recognises that the use of information is an important aspect in supporting the delivery of cost effective and efficient services. The Board is committed to further developing the use of information by the development of more focused information management systems, which will inform clinical effectiveness and in turn improve services to patients.

- **Access to information.** Within the boundaries of appropriate legislation, key healthcare professionals in Shetland will have appropriate access to relevant and understandable clinical information to support clinical decision making and service delivery / redesign. All patient information is managed in a secure and confidential way. Data protection and IT security policies are in place to support staff to adhere to information governance principles. The Director of Finance takes the executive lead for information governance and is also the Data Protection Lead. The Director of Public Health is the organisation’s Cauldicott Guardian.

- **Involving People.** The Board is committed to appropriately informing patients how personal health information is used including how they may access it and who may share it.

- **Training.** The Board is also committed to assisting staff in acquiring the training and skills to utilise software packages that will assist them in the management and utilisation of information.

- **Supporting the delivery of the Information Governance Framework.** The Information Support Group is a sub group of the Clinical Governance Committee and is
responsible for working with the clinical governance operational groups and teams and taking a lead role in the development of the Board information governance framework, IM&T strategies and providing advice on policy development and procedures.

5. Responsibilities of Key Staff

Chief Executive
- Overall statutory responsibility for quality of clinical care and the performance of individuals and teams who provide the service
- Accountable to the Board and the Scottish Government Health Directorate
- Responsible for signing the Statement on Internal Control

Medical Director
- Ensures that clinical quality and effectiveness measures are developed and maintained.
- Leads the implementation of clinical governance at operational and strategic levels.

Director of Clinical Services
- Executive Director with responsibility for delivery of Clinical Governance
- Reports to the Clinical Governance Committee and Chief Executive.
- Senior manager for the service improvement, performance management and clinical governance functions across the organisation.

Director of Human Resources and Support Services
- Director of Human Resources & Support Services is the executive director with responsibility for risk management and health and safety. Risk Management and Clinical Effectiveness functions work together to deliver the Clinical Governance Strategy.

Executive Directors and Senior Managers
- Responsible for driving forward the development and embedding clinical governance across their areas of responsibility. Responsible for reviewing and recording risk to all corporate-level objectives.

The Clinical Governance Committee
- The CGC is a standing committee of the Board with delegated responsibility for ensuring that quality assurance systems are in place. CGC is responsible for ensuring that monitoring arrangements are developed to ensure that quality improvement systems are working well across the organisation. This includes taking an overseeing role for the implementation of the clinical governance and risk management strategies and monitoring risk register activity and controls at regular intervals.

CGC will work with the Board’s Audit Committee where appropriate in relation to risk including preparation of the annual statement on internal control.

Controls Assurance Group
- The Controls Assurance Group (CAG) is a senior management group, chaired by the Chief Executive. It has overall responsibility for the integration, co-ordination
and standardisation of risk management throughout the Board. It will provide assurance to the Board on the establishment and implementation of risk management processes and systems. It will oversee the identification and monitoring of corporate risks, including maintenance of the corporate risk register, and it will deal with significant and escalating risks, reporting formally to the Board six monthly.

The Audit Committee
- The audit committee is a standing committee of the Board with delegated responsibility for ensuring that quality assurance systems are in place. The Audit Committee oversees the corporate risk identification process; whereas the Clinical Governance Committee reviews the corporate level risks and the action being taken to manage them. The Clinical Governance Committee reports back to the Audit Committee on a regular basis.

Clinical Governance Co-ordinating Group
- Multi-professional group representing the CHP and hospital based services.
- Representation is by individuals at Head of Service level.
- Addresses the delivering and supporting aspects of clinical governance.
- Is the formal risk management group for the Board.
- The Clinical Governance Support Team will support the work of the CGCG and all the Board staff as resources and priorities allow.

Senior Nurse Managers and Heads of Department
- Ensure that clinical quality and effectiveness measures are developed and maintained via the Departmental Clinical Governance action plan.
- Commitment to staff development, manpower planning, risk management and dealing with complaints.
- Ensure a high quality service to patients by the continual development of practice according to research evidence and feedback against national standards.

All Staff
Staff have a general responsibility to:
- Initiate action by suggesting/implementing improvements to services.
- Exercising professional responsibility for both themselves and their peers within a fair and open culture.

The Clinical Governance Support Team will co-ordinate and support appropriate multi professional activities to enable staff to deliver and develop clinical governance across NHS Shetland.
6. Implementation

The strategy will be implemented via the following mechanisms.

- Formal arrangements exist for the Board to discharge its responsibility for clinical quality through a Clinical Governance Committee (CGC) (according to MEL (2000) 29).

- The purpose of the CGC is to oversee and monitor the implementation of this strategy and to ensure that necessary systems and structures are in place to assure quality in clinical care.

- The Clinical Governance Co-ordinating Group (CGCG) exists to ensure that clinical governance mechanisms are being developed and evolved throughout the Board. The CGCG steers the implementation of clinical governance at an operational level. The CGCG also acts as the Board’s clinical effectiveness committee and has a specific remit to develop and encourage clinical effectiveness activity. The terms of reference for this group are denoted in Appendix A.

- The CGCG oversees integrated risk management activity across the Board. The Clinical Governance Support Team manage and administer the group to ensure synchronisation of activity and consistent sharing of information.

- The PFPI Steering Group takes a lead role in developing robust structures and processes to develop and embed the principles of PFPI across the Board.

- The Controls Assurance Group (CAG) will oversee the identification and monitoring of corporate risks with their associated actions to minimise risks. The CAG has overall responsibility for the standardisation of risk management throughout the Board.

- The Clinical Governance Support Team organises and supports appropriate multi professional activities to enable staff to deliver and develop clinical governance across the organisation. This department also provides support to all staff across all areas of clinical governance and sources external expertise where this is required.

- Other short life working groups may be developed as required to steer development of areas of clinical governance (e.g. groups aligned to managed clinical networks).

- Clinicians, Managers and Heads of Department will be responsible for delivering and evidencing the components of the clinical governance agenda in a manner appropriate for their area.

- An annual implementation and development plan will be devised by the CGCG.
7. Monitoring

Implementation will be monitored in the following ways:

- As discussed in previous sections the CGC has overall responsibility for assuring the Board of the implementation of clinical governance and the consistently high quality of care. The CGC will receive quarterly reports from the CGCG highlighting progress and challenges across all pillars of governance.

- The CGCG is responsible for supporting and advising on the delivery of clinical governance and will monitor progress through its monthly meetings.

- The Clinical Governance Support Team (CGST) will support and advise on risk activity and provide a briefing to the CGCG on progress across the organisation. The CGCG will receive minutes from all clinical sub groups so as to monitor risk management activity across the Board.

- The CGCG will monitor the progress being made against the clinical governance work plan.

- The Controls Assurance Group (CAG) will monitor corporate risks and maintain the corporate risk register.

8. Communication

- Communication for clinical governance will follow the principles and process outlined in the NHS Shetland Communication Strategy.

- The Clinical Governance Support Team maintains both Internet and intranet sites providing a portal for all staff, patients and service users to access related information. The Clinical Governance Support Team also publishes a quarterly newsletter on clinical governance related activity.

- Minutes, reports and all appropriate documentation from the activities of the CGCG and CGC will be published on both the intranet and Internet.

- All meetings of the above groups and committees are open to staff access.

9. Review

This strategy will be reviewed on a biennial basis by the CGCG with subsequent approval sought from the CGC.
App**endix A**

**CLINICAL GOVERNANCE CO-ORDINATING GROUP**
**REMIT AND TERMS OF REFERENCE**
Updated in November 2009

1. Remit

The Clinical Governance Co-ordinating Group (CGCG) (has been established to) oversees and support the implementation of Clinical Governance throughout Shetland NHS Board area. The group reports to the Clinical Governance Committee, which, as a standing committee of the Board, has the official responsibility to oversee and monitor all clinical governance activity within the Board. CGCG works closely with the Controls Assurance Group (CAG) on risk management. Appendix 1 demonstrates how all the pillars of governance come together. Appendix 2 shows the organisation’s Clinical Governance structure.

Whilst the group will co-ordinate clinical governance activity, Heads of Departments along with their staff are responsible for the implementation and delivery of the clinical governance agenda within their own area.

The Clinical Governance Support Team provide advice and assistance to all Board staff in relation to all aspects of clinical governance activity.

To deliver this remit the CGCG will:

- Lead the implementation of the Clinical Governance Strategy by providing support and advice to all staff on implementation of the clinical governance agenda within their area of practice/responsibility.

- Oversee and ensure the delivery of the range of Clinical Governance activity (see section 9 for definition of range of clinical governance) by liaising with all professional groups and staff groups from hospital-based services and the community health partnership in Shetland.

- Ensure the implementation and monitoring of SIGN Guidelines, NHSQIS Standards and Best Practice Statements locally as appropriate to services provided by the Board through allocating responsibilities to appropriate individuals or groups.

- Act as the Board’s Integrated Risk and Incident Management monitoring group through regular reviews of incident and risk data and oversight of relevant business (see org chart).

- Along with the CAG Develop the Board’s Risk Management Strategy.

- Liaise with / ensure close working relationship with the **Clinical Risk Advisory Team**, which is established to carry operational responsibility for managing clinical risk and poor performance, which includes instigating and overseeing the appropriate course of action for suspected / poor performance, and for significant or potentially significant clinical incidents, including co-ordinating incident management and organisational learning.
Note: the process of Risk and Incident Management is the subject of further development in the context of QIS guidance, and may need further and separate clarification of detail, in addition to the separate guidance contained within the Board’s Significant Incident Procedure.

- Facilitate and support appropriate clinical audit programmes in place across the Board, which reflect local and national priorities.

- Provide advice and support to staff and promote best practice in relation to audit activity whilst monitoring, promoting and reporting on clinical audit and survey work throughout the Board thus ensuring evaluation is taking place.

- Support the development and procurement of educational packages relevant to clinical governance, liaising with the Staff Development Section, so that Board staff are aware of, and can deliver, all the components of Clinical Governance.

- Develop appropriate culture, policy and practice on Clinical Governance within NHS Shetland.

- The CGCG will ensure that due process is followed for all relevant policies and that all relevant stakeholders have been consulted and that a programme of review is in place before advising the Clinical Governance Committee and the Board to approve the policies.

- Clinical guidelines and procedures will be developed and managed within the relevant area of service, as the responsibility of the relevant manager. CGCG may be asked to advise and participate in the process of approval if they affect a range of services or professional groups, or have some other wider organisational significance, or where they differ from national guidance due to local circumstances, in which case the advice and support of the Clinical Governance Support Team, and / or the Chair of CGCG should be sought.

- Keep abreast of national policy initiatives, ensuring implementation of those that require action locally. Maintain an overview of current local issues that may impact on effective Clinical Governance throughout the Board.

- Prepare a quarterly report on clinical governance activity for the Board’s Clinical Governance Committee, and develop the Clinical Governance Strategy for the Board with an associated action plan, which will be reviewed annually, and which will be published on the Internet.

- Promote the Board’s commitment to a Fair and Open Culture acting as an exemplary role model by, for example, holding open meetings from time to time on specific topics of general interest, publishing the agenda in advance on the internet publishing the minutes on the internet ensuring that local policy complies with the diversity standards and that all relevant policies have been evaluated using the EQIA tool. CGCG will invite relevant members of staff or others to meetings for specific items. Members of staff can attend by arrangement with the Chairman.
2. Membership

<table>
<thead>
<tr>
<th>Position</th>
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<tbody>
<tr>
<td>Medical Director (Chair)</td>
</tr>
<tr>
<td>Assistant Director of Clinical Services</td>
</tr>
<tr>
<td>2 Nursing representatives, the Nurse Director and a Senior Charge Nurse</td>
</tr>
<tr>
<td>CHP 3 places including CHP Clinical Lead or his/her Deputy, Assistant</td>
</tr>
<tr>
<td>Director of Nursing (Community) and 1 other representative</td>
</tr>
<tr>
<td>Staff Governance Representative</td>
</tr>
<tr>
<td>Consultant Representative</td>
</tr>
<tr>
<td>Allied Health Professionals Representative</td>
</tr>
<tr>
<td>Pharmacy Manager</td>
</tr>
<tr>
<td>CADO or nominated Dental Representative</td>
</tr>
<tr>
<td>Public Health Representative</td>
</tr>
<tr>
<td>Healthcare Scientists Representative</td>
</tr>
<tr>
<td>Mental Health Representative</td>
</tr>
<tr>
<td>Health and Safety Manager</td>
</tr>
<tr>
<td>Clinical Governance Co-ordinator</td>
</tr>
<tr>
<td>Risk and Incident Co-ordinator</td>
</tr>
</tbody>
</table>

3. Chair of CGCG

The Chairman of the CGCG will be the Medical Director. The Vice Chair will be the Nurse Director.

The role of the chair is to act as lead on clinical governance within the organisation as well as to chair meetings.

4. Responsibilities of Members

The members of the CGCG should:

- Attend meetings.
- Give a range of opinions that reflects the breadth of services within the organisation (Members are not there to represent their professional group)
- Play a part in the co-ordination of Clinical Governance throughout the Board, by taking responsibility for the actions of the Group as described in its remit
- Act as an effective conduit between the Clinical Governance -Coordinating Group and the rest of the organisation
- Send apologies and any comments in advance to the Secretary or Chair of the CGCG if unable to attend.
- Members are asked to make every effort to attend meetings and to be actively involved in them.

Quorum:
The group shall be quorate with 5 members of whom at least 3 should be clinical.
5. Terms of Reference – Meetings

The group will meet 6-8 weekly. The Clinical Governance Co-ordinator will plan dates annually.

The Clinical Governance Co-ordinator will provide secretarial support to the group including minute taking, and agenda setting in consultation with the Chairman.

Meetings will be structured around standing agenda items so that all aspects of Governance can be covered. The agenda will be arranged as follows:

- Apologies
- Minutes from last meeting.
- Matters arising not covered by agenda.
- Clinical Effectiveness. (Including Audit review)
- Risk Review. (Quarterly review of incident data)
- National Standards & guidance (Including preparation for QIS peer review and where appropriate feedback on progress on action plans from previous peer review)
- General Clinical Governance items and development issues covering the range of Clinical Governance concerns.

CGCG will co-ordinate the business of the Clinical Governance Committee, ensuring that the range of Clinical Governance matters are presented to and discussed at Committee over the course of the year.

6. Disseminating Information to Staff.

The CGCG recognises the importance of ensuring staff are fully apprised of its activities and the subsequent development of clinical governance throughout the Board. All staff will therefore be able to:

- Attend meetings of CGCG as observers by arrangement with the Chair.
- Raise issues relating to Clinical Governance (and represent them as appropriate) at the CGCG, through one of the members of the group or the Clinical Governance Coordinator.
- View minutes of the meetings on the Internet.

There may on occasions be matters discussed that require a greater degree of confidentiality and which would be excluded from disclosure within the terms of Data Protection or Caldicot guidance. These may be discussed in a private session and minuted separately.

7. Reporting Arrangements

i) CGCG

The Chairman of the Clinical Governance Co-ordinating Group will report directly to the Board’s Clinical Governance Committee, as well as reporting directly on Clinical Governance matters to the Chief Executive. Additional reporting arrangements will be via the Clinical Governance Co-ordinating Group, members present at the Board’s Clinical
Governance Committee meetings and via the submission of a quarterly report on Clinical Governance activity. The Clinical Governance Coordinator will be responsible for writing the Quarterly Report.

ii) Governance sub groups

The following groups report into the CGCG to ensure that there is appropriate communication of key actions around governance issues across the organisation (both vertically and horizontally):

- Resuscitation Committee
- Health and Safety Committee
- Area Drugs and Therapeutic Committee
- Hospital Transfusion Committee
- Staff Governance Committee
- Control of Infection Committee
- Radiation Safety Committee
- Nutritional Care Steering Group
- Patient Safety Implementation Group

8. Pillars of Clinical Governance

For the purposes of the work of the CGCG and the development of clinical governance within NHS Shetland, the following definition from NHS Quality Improvement Scotland is used to describe the elements of clinical governance:

The NHS Quality Improvement Scotland (NHS QIS) standards for clinical governance and risk management have been developed to support all NHS Boards to put in place the necessary systems and processes to ensure that safe, effective, patient-focused care and services are being delivered across Scotland.

The standards are the conclusion of a two year process of development and consultation by a multidisciplinary project group, whose members have been drawn from a range of backgrounds, reflecting the many dimensions of healthcare governance.

The scope of the standards covers all aspects of clinical governance and risk management from the perspective of patient outcomes, and incorporate the following elements:

**Standard 1 - Safe and effective care and services**

- Risk management
- Emergency and continuity planning
- Clinical effectiveness and quality improvement

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

- Access, referral, treatment and discharge
- Equality and diversity
- Communication
Standard 3 - Assurance and accountability

- Clinical governance and quality assurance
- Fitness to practice
- External communication
- Performance management
- Information governance
Organisational chart denoting the reporting and accountability lines for clinical governance and strategic risk management in 2009-10
* Strategic lead for clinical governance. ** Standing committees are responsible for ensuring the Board that appropriate governance arrangements are in place.
## Appendix B

### Clinical Governance Key Performance Indicators (KPI) for 2010-11

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator/Measures</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Meet the requirements of the NHS QIS Clinical Governance and Risk Management standards</td>
<td>Position on NHS QIS Quality Improvement scale. Revision of procedures, policies and strategies by mid 2010</td>
<td>Improved position against the NHS QIS improvement scale.</td>
</tr>
<tr>
<td>2. Review the education and training programme to ensure it meets the needs of staff across the organisation</td>
<td>Availability of a range of training opportunities to support clinical governance activity. Positive Evaluation of Training courses</td>
<td>Clinical governance principles training programme to be established with 80% satisfaction with training delivered</td>
</tr>
<tr>
<td>3. Further revise the quarterly reporting documentation to ensure that all governance activity is captured in summary form.</td>
<td>Revised report format is established and circulated. Positive feedback gained from CGC and CGCG.</td>
<td>Introduce revised/streamlined reporting by June 2009</td>
</tr>
<tr>
<td>4. Continue to support core audit activity and maintain audit programme across the Board</td>
<td>Audit programme is in place. Positive feedback in respect of audit activity and action plans is noted by CGC and CGCG.</td>
<td>Rolling audit programme is agreed by June 2009</td>
</tr>
<tr>
<td>5. Ensure that progress is made against the CGRMS strategic action plan</td>
<td>Progress is made against the targets set</td>
<td>Improved position against at least 50% of the targets set.</td>
</tr>
<tr>
<td>6. Ensure that risk management KPIs are met for 2009-10</td>
<td>KPI plan is agreed through CGCG.</td>
<td>All KPIs delivered by the end of 2010-11</td>
</tr>
</tbody>
</table>
Appendix C

Further Reading, References and Glossary of Terms

The above represents the Clinical Governance Strategy for NHS Shetland. It does not provide detailed information on the management of a specific area of governance. It is recommended, therefore, that this document be read in conjunction with the following:

- Corporate Governance Handbook (including Standing Orders and Standing Financial Instructions)
- Clinical Governance Annual Report /Strategy
- Organisational policies including the Incident Reporting Procedure, Risk Assessment procedure, Risk Register and Health and Safety Control book for Managers.

- Staff Governance procedures and policies
- Patient Focus and Public Involvement Strategy and Performance Assessment Framework

References

1. Risk Management Standards Australia/New Zealand 4360:2004
2. Combined Code of Practice on Good Corporate Governance (Turnbull, 1999)
3. MEL (2000) 29, Clinical Governance
4. MEL (1999) 75, Guidance on Clinical Governance
5. MEL (1999) 14, Corporate Governance in the NHS
6. HDL (2001) 74, clinical governance arrangements Scottish Executive Health Department 2001
7. HDL (2002) 11, Corporate Governance Statement of Internal Control
9. HDL (2004) 37, Community Health Partnerships (CHPs) and Integrated Mental Health Services
12. The Scottish Government Better Health Better Care Action Plan
14. The Scottish Patient Safety Programme
Abbreviations

CGCG – Clinical Governance Co-ordinating Group
SMT – Senior Management Team
SIGN - Scottish Intercollegiate Guidelines Network
CGST – Clinical Governance Support Team
CHP – Community Health Partnership
CGC – Clinical Governance Committee
ToR – Terms of Reference

Further Reading

Edinburgh: SEHD Patient Focus and Public Involvement:

www.scotland.gov.uk.uk/library3/health/pfpi-00.asp