



NHS Grampian

Local Interim Report ~ *June 2005*

**Clinical Governance and Risk
Management Arrangements in
NHSScotland**

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1 Local NHS system and services

This report presents the findings from the peer review of **NHS Grampian**. This review meeting took place on **14 December 2004**.

Grampian is situated in north-east Scotland and has a population of around 523,390. About 40% of the local population live in Aberdeen, which is the largest urban area in the region, although a significant proportion lives in rural areas. The proportion of older people in the population is lower than the national average, as are levels of illness and deprivation.

Context

In 2002, a management consultancy reviewed NHS support services in Grampian. The Board decided to pursue integration early, and began consulting with the public and liaising with the Scottish Executive in 2003. In September of that year, a single-system steering group was formed. NHS Grampian now brings together a former Primary Care NHS Trust and a former Acute Hospitals NHS Trust. At the time of the review, it contained four divisions in 'shadow form': an acute division; Moray Community Health Partnership (CHP); Aberdeen CHP, in which mental health services are based; and Aberdeenshire CHP.

2 Single-system working

NHS Boards should retain their focus as boards of governance, embodying a corporate, inclusive approach to collective decision-making which is based on the principles of partnership working and delegation of powers to the front line of patient care. NHS Boards should support local leadership by delegating financial and management authority as far as possible; and encouraging locally responsive approaches to service provision.

Operating divisions, as integral parts of local NHS systems, should have specific delegated authority to act within a defined remit without constant reference to the NHS Board. This must be backed up by clear, formal schemes of accountability. Responsibility and decision-making should be devolved to staff who are directly involved in delivering healthcare.

Corporate decision-making arrangements at NHS Board level

During the review meeting, Board representatives discussed NHS Grampian's commitment to creating an effective single system; however, the evidence submitted by NHS Grampian did not, overall, reflect the early planning and smooth implementation that was reported.

NHS Grampian submitted a variety of charts showing reporting lines and accountability lines among various related groups, committees and staff. Even from the most recent of these, however, reporting and accountability lines were often unclear. For instance, there did not appear to be any formal links between the operational management team and the performance governance committee which oversees performance management. Also, reviewers were unsure how the roles of the chief executive officer and chief operating officer compare, and how their functions differ in practice. Board representatives explained that NHS Grampian is working to redress its committee structure, and that challenges still lay in breaking down organisational boundaries in the development of CHPs.

Board representatives described clinical workshops and indicated that liaison between GPs and consultants who have particular influence in key areas has increased and improved. A clinical leadership group had recently been formally constituted, founded from the previous work of five lead clinicians referred to as the 'gang of five'. While reviewers considered strong clinical leadership important, they noted that clinical leadership pertains not exclusively to the medical profession but to other professions as well, and they would encourage NHS Grampian to improve and formally recognise multidisciplinary working.

In general, reviewers recognised that there is considerable activity of merit at NHS Grampian; however, corporate decision-making and arrangements for local implementation at NHS Grampian appeared people-dependent and reliant on individuals' relationships, rather than on systems and clear lines of accountability as detailed in HDL(2002)11 and HDL(2003)11. Reviewers would encourage the Board to demonstrate a strategic commitment to its focus as a board of governance, while devolving powers to operational level in as straightforward and practical a way as possible.

Regional and local decision-making arrangements

The chief executive of NHS Grampian sits on the North of Scotland Planning Group, and Board representatives deferred to this post regarding evidence of regional planning. Reviewers noted the chief executive's high-level representation on this regional planning group, and noted that NHS Grampian and the regional planning group have an interdependent relationship. In particular, reviewers identified potential governance issues in terms of performance review with other NHS Board areas. Board representatives reported that there are governance links and feedback mechanisms with NHS organisations with which it shares a land border, such as NHS Highland and NHS Tayside. NHS Grampian acknowledged that links with island NHS organisations, such as NHS Orkney and NHS Shetland, need to be improved. Reviewers suggested that NHS Grampian's shared governance links with Island NHS Boards take into account potential dependencies of remote Boards on mainland ones.

Board representatives stated that NHS Grampian has used the legislation for single NHS systems as an impetus for initiating whole-system approaches to regional planning. During the review, they indicated that, so far, the focus has been on areas in which local enthusiasm has helped assure success (for example, on collaborative multi-sector working to screen for, and treat, diabetes). Reviewers considered this a positive beginning, and would encourage NHS Grampian to focus on working across healthcare boundaries and with other partner agencies to deliver smoother patient journeys in a multitude of areas.

Performance management at NHS Board level

It was stated that NHS Grampian has, as a Board, moved towards increasingly trusting its committee structure to deliver the detail of performance management work. Reviewers considered, however, that in light of the lack of clarity of the committee structure, it might prove difficult for the Board to rely fully on this. It was indicated during discussion that performance management within NHS Grampian is in development.

Operationally, Board representatives stated that senior staff from the CHP/operating division local units meet with the chief operating officer three times a year. From these local meetings issues arising from, for example, NHS Quality Improvement Scotland reviews and Scottish Executive accountability reviews, are identified. The performance governance committee oversees performance governance and reports directly to the Board. It prepares for the Board bi-monthly exception reports based on detailed performance management reports on key performance issues and risks that the committee has discussed.

During discussions, reviewers were unable to ascertain how NHS Grampian defines an acceptable level of performance in relation to which exceptions (eg under-performance, risks and vulnerabilities) can be identified. It was not clear to reviewers what constitutes an exception within the NHS Grampian system, or how exceptions or under-performance are systematically reported. Board representatives stated that, presently, exceptions are determined through discussion during reviews of each unit, but acknowledged that a systematic approach is lacking. Reviewers would encourage NHS Grampian to further develop the use of exception reporting in a more formalised manner to determine consistent levels of acceptable performance, and to link performance management acceptability to risk management and corporate objectives.

In 2005, the Board intends to bring together indicators from various reviews to create a streamlined set of corporate objectives.

It is clear that there is a great deal of activity and change in NHS Grampian with obvious individual enthusiasm. However, in terms of overall governance within a single system, deriving assurance from the evidence provided was not straightforward; plans, charts and minutes were not clear and at times seemed contradictory, and documentation dates were inconsistent. Overall, effective documentation and document control could support the Board's ability to govern systematically and to evidence management of performance over the whole organisation.

Emergency planning arrangements

At the time of the review, no documents detailing emergency planning arrangements were submitted by the Board. NHS Grampian participates with the Grampian Joint Emergencies Executive Committee. At operational level, plans are developed based on central guidance and knowledge of local circumstances, and are tested by table-top and live play exercises. Reviewers suggested that planning also includes contingencies for internal events that could disrupt service continuity (eg failure of sterile supplies, fire or explosion, short-term staffing crisis, laundry failure etc).

Internal and external communication strategies and scheme of delegation

NHS Grampian has adopted a communications strategy, the objectives of which have been accepted by the Board. Board representatives reported that this overarching strategy brings together several component strategies and aims to give consistent direction to communications in NHS Grampian. Board representatives stated that the strategy's implementation is monitored through patient focus public involvement (PFPI) work, and by the local health council; reviewers suggested that monitoring of strategy implementation could also be linked to performance monitoring.

Reviewers emphasised the importance of frequent and clear two-way communications with stakeholders including staff, especially during this period of transition. One technique used to disseminate information quickly among key staff is the NHS Grampian Management Information Exchange (MIE), in which 100-150 staff members are brought together to hear information first-hand and ask questions directly at the time.

Current position

Strategic development and operational delegation of service planning is in line with the principles of single-system working but is only partly reflected in organisational frameworks and arrangements for implementation and feedback.

3 Clinical governance

In order for NHS Boards to plan, provide and improve services, they must have in place structures to monitor and improve the quality of services. A clinical governance framework should be in place to support and monitor standards of care; create an environment for the continuous improvement of services; support strategic planning; and facilitate service delivery.

Clinical governance strategy and committee

At the time of the review, NHS Grampian did not have a clinical governance strategy; rather, the Board stated that strategy for clinical governance was ‘conceptualised’ throughout its work, including within the local health plan. It was, however, unclear what this meant in practical terms. Nonetheless, a new structure for clinical governance has been defined, including a clinical governance support unit and a clinical governance work plan. Board representatives indicated the intention to develop this unit and a clinical governance strategy in 2005; a clinical governance lead was appointed in November 2004 with responsibility for drafting this document.

During the review, Board representatives reported that there was an element of concurrent and overlapping activity between previous and new clinical governance arrangements. Perhaps because of this, the organisational structures regarding clinical governance seemed unclear to reviewers. Documentation detailing current arrangements was confusing, with multiple versions and a variety of organisational charts. NHS Grampian provided evidence that it has both a strategic and operational clinical governance committee. Reporting lines between these and, for example, the operational management team, were not fully clear.

A clinical governance report/network structure, submitted by the Board at the review, showed that the operational management team is not directly accountable to the Board, but instead links to CHP subcommittees and a clinical governance operational committee, which then links indirectly to the Board. The Board submitted evidence that some governance activity is addressed by the performance governance committee; however, reviewers noted that MEL(2000)29 requires a separate clinical governance committee to oversee clinical governance and report directly to the Board. Furthermore, a principle requirement of HDL(2003)11 is for responsibility and decision-making to be devolved to those directly involved in delivering healthcare, and NHS Grampian’s clinical governance reporting/network structure should reflect this.

Overall, reviewers would encourage NHS Grampian to demonstrate greater corporate ownership of clinical governance, to match the leadership and ongoing enthusiasm at operational level. They suggested clarification and documentation of current arrangements to provide assurance, even during this interim period of change. For the future, mechanisms for prioritising clinical governance issues could help facilitate the clinical governance committee’s overseeing role, and help facilitate the clinical governance unit’s support of operational practising and delivering roles.

Embedding clinical governance throughout the service

Board representatives indicated that clinical governance is integral to all NHS Grampian activity. However, there was little written evidence of this, leading reviewers to query how the Board receives assurance of effective clinical governance with no single-system

strategy, and no apparent Board-level clinical governance framework. It appeared that NHS Grampian was in some ways still reliant on predecessor governance arrangements.

The recent appointment of a clinical governance lead was seen as a positive step, but reviewers noted that for clinical governance to become established, and then embedded within NHS Grampian, this lead post and the clinical governance support unit needs to be recognised and supported both at Board and operational level. Ultimately, practising and developing clinical governance activity should rest not with a clinical governance lead but with local clinical teams; the clinical governance support unit should function by offering tools and advice.

Clinical effectiveness

Reviewers were satisfied with the clinical effectiveness strategy submitted by the Board. During the review, Board representatives gave examples of clinical leadership and of clinical effectiveness work being used to bring about service change to improve patient care.

Reviewers noted that clinical effectiveness is an element of clinical governance, itself an element of healthcare governance, and suggested that clinical effectiveness work continues to be undertaken and supported within this larger frame of reference.

Current position

Strategic development and operational delegation of clinical governance is in line with the principles of single-system working but is only partly reflected in organisational frameworks and arrangements for implementation and feedback.

4 Risk management

Effective risk management and risk reduction lies at the heart of governance. It informs the use of resources, supports the delivery of safe, effective care and promotes a learning, no-blame culture that uses experience as a valuable means of improving care. It is also required at statutory level and is a key element of internal and external audit. NHS Boards are required to carry out risk assessment at every level and to develop a corporate risk management strategy which identifies key risks and associated actions and their priorities.

Risk management approach at strategic level and for delegated functions

Reviewers were pleased to note the progress made in the development of the NHS Grampian risk management strategy, though they expected that implementing and monitoring it might prove challenging. The implementation plan for the strategy seemed aspirational; in particular, the timescales in the plan indicate many tasks to be completed in December 2004 and January 2005, some of which were already slipping. Reviewers would encourage that this risk management work be prioritised in order to keep to timescales and not lose momentum.

At the time of the review, NHS Grampian indicated that it held three corporate risk registers. Board representatives stated that they are trying to 'harmonise' their approach to risk management, bringing together two existing cultures which reflect the previous two differing Trust sectors. NHS Grampian aims to increase staff ownership and clinical leadership of risk management, and has focused on educating staff to understand identification of risk, and establishing risk criteria so that staff can determine when and how to escalate risks. Reviewers noted that a consistent set of risk criteria are a crucial step in maintaining a risk register.

NHS Grampian is trying to eradicate a blame culture so that staff feel comfortable reporting incidents; in this, they have met with some success as evidenced by data showing a large increase in incident reporting in the acute sector over the past 18 months. During discussion, risk management staff noted that the majority of incidents reported are near misses. They added that this is suggestive of a change in reporting culture. This risk profile is now recognised, and NHS Grampian staff suggested that it might now be appropriate for the Board to begin analysing risk trends, and to promote local analysis and change as a result of the data rather than focusing on individual risks.

The Board's current emphasis appeared to be on the risks associated with under-performance, rather than on managing risk overall, which might impact on the organisation either now or in the future. Reviewers noted that risk management requires to be a consistent element in internal control and decision-making, and that it and clinical governance are therefore essential for the Board's role as a Board of governance. Reviewers suggested that the relationship between clinical governance and risk management be strengthened, and that strategies for, and implementation of, these be aligned with one another. In terms of risk management's relationship to performance management, Board representatives reported that risk was in the early stages of being 'built into' performance management at NHS Grampian. Reviewers noted that an IT system could help facilitate this, and NHS Grampian indicated that it is in the early stages of procurement. As with clinical governance, reviewers identified a need for the

executive team to be engaged in ongoing development and regular review of issues arising, to ensure that clinical governance and risk management link into wider strategic planning by the Board.

Overall, reviewers were pleased to note that NHS Grampian appears to be developing a risk profile, and considered the rise in incident reporting to be evidence of a degree of initial implementation of the risk management strategy. While reviewers did note positive developments, there were still areas where further work is needed, such as the establishment of a corporate risk register, the creation of links between risk management and clinical governance, and connecting management of risk with management of performance.

Current position

Strategic development and operational delegation of risk management is in line with the principles of single-system working and is predominantly reflected in the organisational frameworks and arrangements for implementation and feedback.

5 Patient Focus and Public Involvement

(Assessment Report as provided for Section 5 of the Scottish Executive Health Department's Performance Assessment Framework)

The NHS Board is able to demonstrate, through the development and implementation of its Patient Focus and Public Involvement (PFPI) Framework the impact and outcomes of engaging with the public and responding to the needs of individual patients both in terms of individual care and service design, development and review.

As well as this, the NHS Board is able to demonstrate how it is meeting the needs of those subject to discrimination based on their age, disability, faith/beliefs, gender, race/ethnicity and/or sexual orientation as well as consideration of cross cutting issues such as mental health, poverty and homelessness.

5.1. Engaging with the public

5.1.1 The Board is able to evidence the outcomes of involving patients, carers, the public and customers (where appropriate) in the design and development of services in line with their ongoing sustainable frameworks, implementation plans, action plans and the principles of Patient Focus and Public Involvement and Partnership for Care.

The Board is delivering PFPI locally within divisions and this is to be progressed to ensure a system wide approach. Plans are being developed to review the PFPI framework and to ensure delivery of this across Grampian. There are many individual examples of work undertaken within specific divisions and units within the NHS Board as well as the out of hours consultation, the first whole system initiative of its kind. Across these different levels and examples the Board is able to demonstrate that it is working on the principles of Patient Focus and Public Involvement and is beginning to embed these into the everyday working practice. The Board and Local Health Council recognise the commitment to the agenda from all levels throughout the organisation as well as the relationship which exists with the Local Health Council and other partner organisations.

5.1.2 The Board is able to evidence effective governance and performance management systems for Patient Focus and Public Involvement, agreed and implemented with partners, patients and the public.

There is a PFPI Board committee in place that is chaired by a non-executive trustee although it is felt that there is some work still to be done to ensure integration across the single system whilst facing financial constraints and competing priorities.

The good work undertaken within MCNs with dedicated resources should be mainstreamed across NHS Grampian as resources allow. This approach has proved fruitful in terms of outcomes for patients and service delivery. NHS Grampian and the Health Council are agreed that there is little evidence to show how the public are involved in setting and monitoring performance targets, how good practice is being shared and that resources have been allocated to support PFPI activities and these should be priorities for the coming year to ensure that NHS Grampian is able to demonstrate a learning organisation. Capacity is flagged up as being an area for improvement as well as ensuring that PFPI work is coordinated and shared.

5.1.3 The Board is able to evidence the impact of providing support for patients, carers, individuals and customers (including training and information) on improving the quality and extent of Patient Focus and Public Involvement in the design, development and delivery of services.

The self assessment identifies areas where activity is happening at a local level as well as areas where plans have still to be developed. It is felt that the new induction pack (based on the NOSCAN model) for patient and public representatives is one of the strengths of the NHS Board and this is welcomed in ensuring ownership of the agenda. NHS Grampian have adopted a variety of mechanisms and processes for involving patients across the whole system and a shared approach to PFPI with their partner organisations.

The Community Forum provides an opportunity for local well-informed people to be involved, however, further exploration is needed to ensure that the members have the support necessary to undertake the roles that will be expected of them.

Consideration must be given as to how the NHS Board ensures that it is able to provide training, advice and support to patients, carers and the public to engage with NHS Grampian systematically. This is particularly important with the development of Community Health Partnerships and their Public Partnership Forums.

The development of the new corporate strategy for information for patients and the public is to be commended and this should incorporate the emerging national guidance from SEHD when available.

There are strong links through community planning to hard to reach groups and the NHS Board should build on the work undertaken with the Racial Equality Council to ensure this approach is mainstreamed across the organisation.

5.1.4 The Board is able to show evidence of assessing the impact of involving staff in the design, delivery and planning of services.

The Board is able to evidence involvement of staff in designing and planning services across the whole system although it would seem that limited resources are available to make this sustainable in the longer term.

The Board is working through MCNs and they can demonstrate an improved patient and carer experience based on the knowledge of staff working in these areas as well as how information is provided to and received from staff through mechanisms in place and consultation processes.

In relation to working with and involving staff in the design and planning of services, the Board can demonstrate progress being made and can evidence how this is being delivered locally through a variety of different tools and approaches.

There is recognition that staff not only have a role to play in relation to the contributing to a process, but are also a major factor in the wider consultation process; as a result, NHS Grampian is looking at methods of encouraging and supporting staff to participate. There is an awareness of the need to involve staff early in the process and to complete the equality and diversity training for all staff, currently being delivered.

5.1.5 The Board is able to evidence the integration of Patient Focus and Public Involvement principles into training programmes for staff and the impact this has had on direct patient care.

There is some evidence to suggest the integration of PFPI into training programmes however, little is available on the subsequent impacts of this training to improving patient care and everyday practice. In most cases there are plans developed to deal with these issues and there is some evidence of these being implemented locally. Nevertheless, it is encouraging to see the principles being embedded into the yearly appraisal of all staff and the new induction process. Communication skills training is available for staff.

The lessons learned from the Certificate in Public Involvement training should be considered when further developing training programmes. The Health Council have identified the need to provide more consistent training and to develop a learning culture which allows staff support to embed their learning into everyday practice.

5.2. Responding to the needs of individual patients

5.2.1 The Board is able to evidence progress in implementing Fair for All – the Wider Challenge (an equality and diversity approach) and the impact that this has had on the design, delivery and review of services and improving patient experience. This should include the integration of existing policies and strategies.

NHS Grampian can demonstrate progress across the equality and diversity agenda. There is a wide understanding of the agenda and NHS Grampian are currently considering how they plan to integrate this across the whole system.

The self assessment indicates that plans are in place to take a wider diversity approach. The activity has by necessity focussed on race and disability with the Race Equality Scheme in place and the new posts being there to support this work. As work progresses, NHS Grampian should mainstream this approach from the work already underway across the other equality strands.

A proactive approach to the wider challenge of equality and diversity needs to be further implemented. This is clearly a priority for the next 12 months as is the need to impact assess all new policies and functions in line with emerging guidance from SEHD. We would expect to see progress on this area over the next 12 months.

5.2.2 The Board is able to evidence how feedback from the comments, compliments, concerns and complaints process is used to improve the experience of individual patients and carers and inform service design, development and delivery.

A complaints team has been established within the NHS Board and they are producing a unified complaints report to cover the whole system. This should allow for the identification of trends and common themes across the whole organisation and also present opportunities for learning.

The complaints team now deals with informal feedback and comments and whilst this may prove useful, this should be monitored to ensure that people are not put off by the complaints team handling these issues.

There is recognised commitment from the Board and support from the Community Forum.

Both the NHS Board and the Health Council have identified the need for improving response times, development of a systematic approach to learning from complaints, providing feedback to complainants and the ability to share good practice across the organisation.

There is training available across a number of staff sectors which looks at improving their skills and understanding in dealing with positive and negative feedback as well as complaints from patients, carers and the public. It will be necessary to ensure that all staff groups have access to this training and that this incorporates the vision set out in the new complaints procedure when available.

5.2.3 The Board is able to evidence how it responds to the needs of individual patients and the impact that other aspects of the Patient Focus and Public Involvement agenda have had on service planning and delivery and improving the patient experience. This should include volunteering, advocacy, voluntary sector engagement, patient information and carer engagement.

With the move to a single-system NHS Grampian have had to review a number of policies and strategies, this includes their volunteering policy. Plans are underway to ensure that the new Volunteering policy takes accounts of the survey of volunteers undertaken in 2004. This should be a priority for the next 12 months.

There is a clear advocacy plan and associated action plan developed in conjunction with the three local authorities which will ensure that those who require advocacy services have access to it.

There is a spiritual care policy and spiritual care committee in place and a considerable amount of effort is being put into mainstreaming this across the system. Consideration should be given as to how this fits with the emerging equality and diversity agenda.

The newly approved Patient/Public Information Strategy has been commended by the Local Health Council and congratulations should go to the Board for their input in developing the national guidance for use by NHS Boards.

Further consideration should be given as to how the NHS Board will use the patients experience to inform future service design and delivery and this should be given further consideration over the next 12 months.

Whilst Aberdeen City CHP have identified the development of a voluntary sector compact between the CHP, local authority and voluntary sector, it is unclear how the NHS Board plans to incorporate these into a Grampian wide compact. This should be a priority for the next 12 months.

6 Strengths and challenges

Strengths:

- Reviewers identified that effective operational delegation of risk management is reflected in organisational frameworks, and would encourage that arrangements for further implementation of risk management systems and feedback to staff about key risks build on this existing effectiveness.
- Enthusiastic, knowledgeable and committed staff.

Challenges:

- A vital challenge for NHS Grampian is to improve its strategic development and operational delegation of clinical governance.
- Another challenge is to establish organisational frameworks and arrangements for implementation and feedback for clinical governance and performance management issues.

Appendix: Review team members

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