Board Strategy

National Waiting Times Centre Board

Clinical Governance Strategy

Name	Clinical Governance Strategy
Q-Pulse No	Board-Strategy-3
Summary	Outlines the Board's approach to delivery of safe and effective care through the establishment of a robust clinical governance framework
Associated documents	Risk Management Strategy Involving People Strategy
Target audience	All staff of the National Waiting Times Centre Board
Version number	Version 3
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Date of full impact assessment	N/A
Name of Board	National Waiting Times Centre Board
Approving committee/group	Clinical Governance Committee
Document author	Mark Swatton

Strategy developer (Author): **Mark Swatton**
Strategy developer's designation: **Head of Clinical Governance**
Is this a new strategy**? No**
If 'Yes', why is it required? (e.g. new legislation necessitating Board compliance)
If 'No', reason for reviewing current strategy: (e.g. strategy review date expiring, change in legislation necessitating policy amendment): **Updated to reflect the Board's change to governance arrangements; reflect reporting changes; reduced in size the removal of unnecessary text; terms of reference for relevant groups/committees updated; updated organisational governance chart added; and to reflect changes to the Clinical Governance Department.**
Who has been involved or consulted with in order to develop this strategy? (i.e. Committees/Working groups, specific individuals, etc.) **Full consultation across Board including divisional clinical governance groups and Clinical Governance and Risk Management Group**
Has this document been assessed for relevance? **Yes**
Is this document relevant for Full Impact Assessment? **No**
Date of full impact assessment (please attach completed EQIA document on submission): **N/A**
How will this policy be implemented across the Board? (e.g. training programme, awareness raising, etc.) **See Section 5**

Content

National Waiting Times Board / Golden Jubilee National Hospital

Clinical Governance Strategy 2013 - 2016

1. 0 Introduction

1.1 This strategy outlines the approach undertaken by the National Waiting Times Centre Board (the Board) in ensuring that clinical governance is being delivered and embedded across the Golden Jubilee National Hospital (GJNH), Beardmore Centre for Health Science and the Beardmore Hotel and Conference Centre.

1.2 Key to this delivery is an approach that looks to integrate existing systems and structures in order to minimise duplication and maximise clinical and non clinical input in order to enhance service delivery.

1.3 This strategy has been updated in 2013 to reflect the changes that have taken place across the Board both internally through organisational review and on a national scale through the launch of the NHS Scotland Quality Strategy in 2010 and the National Person Centred Health and Care Programme.

2.0 Philosophy and purpose

2.1 For the purposes of this strategy the following definition of clinical governance is applied:

"…Clinical governance is the system for making sure that healthcare is safe and effective and that patients and the public are involved..."[1]

2.2 We are committed to ensuring we have in place and continuously monitor the systems, processes and principles (collectively known as Clinical Governance) which allow us to deliver care, which is of the highest quality and is:

- Person Centred
- Safe
- Effective

In this way we can assure the public, patients and staff that our services are of the highest standard with the needs of patients and service users at the centre of all decision-making.

2.3 To achieve this we will ensure relevant infrastructure, policy and process are in place.

2.4 Implementation of our strategy requires the ownership and support of ***all staff***. Clinical governance is not a separate function carried out on behalf of staff. Whilst this strategy is titled 'clinical governance', it does not just apply to 'Healthcare Professionals'[2] as the principles contained within can be applied by all staff whatever role they undertake.

[1] NHS Quality Improvement Scotland, 2006

[2] Defined as professionals including Clinical/ Healthcare Scientists, Doctors, Nurses, and Allied Health Professionals

2.5 We will implement this strategy in the spirit of the Board's vision and values framework. We support and promote a fair and open culture which accepts that whilst mistakes may be made our response to these should not be punitive rather we will understand what went wrong and put actions in place which will reduce the risk of recurrences.

3.0 Framework for delivery

Our strategy is delivered through the following framework:

3.1 Effective. Effective care is supported by:

(a) Standards. These aim to support continuous improvement in the standard of care in terms of process, outcome and knowledge. Specifically:

- Standards should be based on appropriate evidence base and implemented consistently in order to minimise unacceptable variations in service delivery.
- Development of local standards is encouraged as is appropriate.
- The Board will meet when appropriate, and exceed where possible, the standards defined by NHS Healthcare Improvement Scotland (HIS) and other external organisations.
- Non clinical departments will be expected to confirm to relevant standards as appropriate to their function.

(b) Clinical Audit and Improvement. Clinical audit / improvement forms part of professional practice. All healthcare professionals are expected to participate in clinical audit activity[3] to drive improvement in standards. The Board is actively involved in national audit programmes and all clinical teams collect and utilise outcome data. Each Division is expected to produce and deliver an annual clinical audit and improvement plan.

The Board uses a number of quality improvement tools including LEAN and Plan Do Study Act (PDSA) cycles as associated with the Scottish Patient Safety Programme (SPSP). We will continue to develop and apply appropriate Quality Improvement Methodologies across all areas of the clinical governance agenda applying these to clinical and non clinical activity.

Staff from non clinical functions are also encouraged to continuously improve the quality of their work through audit and other improvement activities.

(c) Clinical Dashboards. Clinical dashboards provide a graphic representation of clinical indicators, which are measures of performance for key areas of practice. Indicators can provide assurance that care is meeting the appropriate standards, or if not, allows improvements to be made. Both Divisions have in place clinical quality

[3] Whether this be through mandatory requirements in Consultant Work plans and Knowledge and Skills Framework (KSF) job outline or through service / team development

dashboards and all wards have in place quality improvement dashboards. The use of dashboards will be rolled out across all areas of the Board.

(d) 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 screened and disseminated to staff through the Clinical Governance Department (CGD) and discussed for relevance at the relevant Divisional Clinical Governance Group (DCGG). Guidelines are implemented through the appropriate group and where there is a pan organisational guideline delivery of this is overseen by the Clinical Governance and Risk Management Group (CGRMG).

The Board also supports, where appropriate, the robust and rigorous development of local guidelines. Clinical staff are also encouraged to use guidelines from their professional bodies and other appropriate sources to inform their practice.

(e) Document Management. It is important that all staff have access to relevant documents, whether these are corporate policies or local procedures and protocols. The Board has in place 'Q pulse' as its document management system.

3.2 Safe. Our **Risk Management Strategy** outlines the detailed structure and process for all risk and safety activity. In summary:

(a) Risk Management Process. The Board will continue to develop and refine risk management processes, specifically incident management and risk assessment, which integrate clinical and non clinical aspects of risk 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 is fostered and risk management is considered the business of all staff at all levels within the organisation.

(b) 'Responsibility' Culture. The Board has published a Fair Blame Policy, which is applicable across all areas of the Board. Such a culture promotes responsibility and accountability amongst staff. It acknowledges that whilst errors occur, only those that are intentional, knowing, reckless or negligent require a punitive response.

Staff are to be encouraged to report incidents and near misses and these should be used to formulate plans to reduce the risk of them occurring. The CGD will support managers and lead clinicians in feedback learning and action plans from such events.

(c) Complaints and Litigation Management. The Board is committed to listening carefully and responding appropriately to complaints ensuring that systems are in place so that lessons are learned. The Board's complaints procedures follow national guidance and are updated appropriately. Training on handling complaints is held regularly and written guidance is available for all staff. The Board also follows a

robust and systematic approach to litigation management which is underpinned by the Claims Policy and associated procedure.

(d) Electronic Support for Risk Management *– Datix.* The Board's risk management information system is Datix. This system allows for efficient and effective electronic management of risk registers, incident reporting, standards co-ordination, claims and complaints handling.

(e) Scottish Patient Safety Programme (SPSP). In 2008 the Board commenced work on the Scottish Patient Safety Programme, a national initiative aimed at improving safety by driving down mortality rates, reducing avoidable harm, adverse incidents and reducing hospital acquired infection. This is achieved by delivery of a number of change packages, developed from evidence-based practice and delivered using a quality improvement model based on rapid test cycles of change. Progress is monitored through robust data collection and plotted on a central database. The Board continues to improve its arrangements for delivery of the SPSP.

3.3 Person Centred. The Board's approach to delivering Patient Focus Public Involvement (PFPI) and the wider equality agenda is outlined in more detail in its **Involving People Strategy**. In summary:

(a) Involving People. The Board actively looks to provide opportunities for staff, patients, members of the public and representatives from the voluntary sector to become involved in activities related to clinical governance and quality improvement.

The Board has developed a robust structure to ensure patients and members of the public can be involved appropriately. The Quality Patient Public Group (QPPG) is the central group to coordinate and oversee this activity and to liaise and support the Board in delivery of its quality agenda from the patient public perspective.

(b) Equality and Diversity. The Board's approach also incorporates the delivery of the general and specific duties of the Single Equality Act. The Involving People Group is charged with development and implementation of all strands of diversity supported operationally by the Equalities Steering Group.

(c) Feedback. Feedback informs service improvement and is a key element of the **Involving People Strategy**:

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

- Patient and staff views are actively sought through Speak Easy, the Board's comments and suggestions scheme.
- Complaints provide an important source of feedback.

3.4 The Role of Corporate Functions in Delivery of Clinical Governance and Quality. Good clinical governance and associated high quality care must be delivered in collaboration between corporate functions:

(a) eHealth. The Board's strategic and operational approach to delivering all elements of ehealth is outlined in more detail in its **eHealth Strategy.** The core objectives of the **Clinical Governance Strategy** concerning eHealth 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. We are committed to further developing the use of information by the development of more focused clinical 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 at the GJNH site 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.

- ***Involving People.*** The Board is committed to appropriately informing patients about how their 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.

- ***eHealth Steering Group.*** The group is responsible for taking a lead role in the development of the Board's **eHealth Strategy** and providing advice whenever this is sought. The CGD will support this process as appropriate.

(b) Learning and Development (L&D). The Board's strategic and operational approach to delivering comprehensive training and education for all staff is outlined in more detail in its **Learning and Development Strategy**. The core objectives of the agenda as they apply to the **Clinical Governance Strategy** 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 across all elements of this strategy.

- ***Training.*** Will be coordinated both internally:

    - ***By the CGD.*** Generic courses across all pillars of governance will be available to met needs of divisional teams. Specifically, training on risk management, equality and diversity and clinical effectiveness (mainly around clinical audit management and quality improvement).

- ***By the CGD.*** The team to provide learning opportunities for all Board staff will deliver periodic Clinical Governance Seminars.

- ***By the Clinical Educators.*** In the main, support Nursing although they will contribute to other initiatives as appropriate.

Training will be sourced externally where internal training and development cannot be provided.

- ***Measuring and Supporting Development of Staff Performance.*** All staff have updated job descriptions and Knowledge and Skills Framework (KSF) job outlines, which indicate the requirements of their post. Requisite skills to equip them to deliver high quality care are explicit in these outlines. Where skills gaps exist support will be provided to develop the required skills and understanding.

- ***Organisational Change and Team Development.*** The Board recognises the importance of supporting teams across departments to grow and develop often in times of change and processes are in place to provide this support through the L&D team.

- ***Knowledge Services.*** All elements of this strategy require staff to be provided with the latest information and data in order to provide safe and effective care. The Board has developed a broad and inclusive **Knowledge Services Strategy,** which draws together all the key themes required to meet the requirements of the quality assurance framework for knowledge services.

(c) Performance management. In order to both measure and drive performance across the organisation, the Board has in place a Local Delivery Plan (LDP) which is informed by Local and National priorities. In summary:

- This strategy complemented by the Board's Clinical Improvement Policy and its **eHealth Strategy** helps objectives and targets to be met through ensuring that data is gathered and analysed quickly, with the delivery of care and interventions underpinned by developing a strong evidence base, which is audited for effectiveness.

- The Board's **Risk Management Strategy** helps ensure risks are identified and appropriately managed. Risks are linked to objectives and performance targets indicated in the LDP, so that informed decisions can be made about the most effective use of resources in the delivery of targets.

- The Board's **Involving People Strategy** provides the framework for involving people in the development of the LDP.
- The Board has in place a Performance and Planning Group, which meets monthly to monitor performance across the Board. This is achieved through scrutiny of performance packs for all divisional and corporate areas.

(d) Communication. The importance of communication, in all forms, for the delivery of the clinical governance agenda cannot be underestimated. The CGD will work closely with the Corporate Affairs Department to ensure that all forms of communication are utilised to their maximum effect to support the delivery of the quality ambitions. Where appropriate communications plans will be developed to support specific pieces of clinical governance activity.

(e) Research. Significant progress has been made in advancing the Board's research agenda. Full details can be obtained through the **Research and Development Strategy**. In summary:

- ***Research Priorities*****.** The Board acknowledges the importance of following the research priorities outlined by The Chief Scientist Office (CSO) in the Research Strategy for Health and Healthcare (2003). There are three main clinical priority areas: cancer, cardiovascular disease/stroke and mental health. Cardiovascular disease/stroke is also a local priority. Other local priorities include orthopaedics and anaesthetics.

- ***Research Activity*****.** The Board aims to continually increase the volume of research projects by supporting researchers who recruit to multi-site projects, including those originating from the CSO funded UK Clinical Research Collaboration (UKCRC) initiatives, and actively assisting staff who wish to become Chief Investigators in areas such as protocol design, ethics and research governance procedures, and management of research projects.

- ***Partnerships*****.** Research partnerships with academic institutions represented locally will be fostered.

- ***Learning and Development*****.** Continued development of research activity, particularly the development of local staff as Chief Investigators, depends on the availability of people with appropriate skills. Learning and development activities will map to elements of the Knowledge and Skills Framework.

- ***Information Management and Technology*****.** The Research Governance framework for Health and Community Care makes it clear that systems should be in place to enable staff to access the information they require to take part in research projects (research ethics, research governance, and training), and that the public should be able to access information concerning the research that takes place in the Board that provides their care. The Board's Research Office has focused on this by developing a website that is accessible to staff and to patients.

- ***Research Governance*****.** The Board is committed to implementing the Research Governance Framework for Health and Community Care by taking, and contributing to, best practice in research governance by interacting with other NHS Scotland Research Offices.

- ***Consumer Involvement.*** The Board will facilitate consumer involvement in research by ensuring that consumers: contribute to the development of research projects sponsored by the Board by enabling them to play an active part in the Board's Research and Development Steering Group; are aware of the Board's Research website and that consumers are invited to Research Events.

- ***Funding.*** Infrastructure support from CSO from the Support for Science funding stream applies to eligibly funded research projects. A list of eligible funding bodies, as defined by the CSO, is available on the CSO website or from the Board's Research Office. Individual projects may be funded by external grants, research endowment funding or from individual's departmental accounts (own account). Part of the research governance activity of the Board's Research Office is to effectively cost each project to ensure that research activity hosted by the organisation does not impact on the clinical budget.

- ***Commercial Research.*** The Board's Research Office aims to promote appropriate contract research (e.g. drug trials with pharmaceutical companies), and joint developments with industry (e.g. partnerships with local companies).

- ***Intellectual Property.*** The Board is committed to the appropriate exploitation of intellectual property (IP) generated through research or clinical work. The organisation works closely with SHIL (Scottish Health Innovations Limited) to facilitate this exploitation, which has the potential to generate an income stream for the Board.

4.0 Responsibilities of staff

4.1 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 Executive.
- Chair of CGRMG.

4.2 Nurse Director

- Executive Director with responsibility for delivery of person centred elements of this strategy. The HR Director is specifically responsible for delivery of equality and diversity elements of this strategy.

4.3 Medical Director

- Executive Director with responsibility for delivery of risk and patient safety and effectiveness elements of this strategy.

4.4 Executive Directors and Senior Managers

- All senior managers have a collective responsibility for driving forward the development and embedding of clinical governance across their spheres of responsibility.

4.5 Divisional Management Teams

- Ensure that robust arrangements are in place across the divisions to deliver all elements of this strategy.
- Show 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.

4.6 Corporate Staff (including those from hotel)

- Will ensure the elements of this strategy are implemented across their respective areas.
- Will attend the Corporate Clinical Governance Group.

4.7 All GJNH Staff have a general responsibility to:

- Initiate action in suggesting and implementing improvements to services.
- Exercise professional responsibility / accountability for both themselves and their peers within a fair and open culture.

4.8 Head of Clinical Governance

- Leads the operational implementation of all elements of this strategy ensuring relevant structure, process and policy is in place and monitored on a periodic basis.
- Provides advice and support to all Board staff on implementation and application of all elements of this strategy.
- Manages the CGD.
- 2 Clinical Governance Leads from within the CGD are allocated to each division to provide practical support and advice for all elements of this strategy.

4.9 Chairs of Divisional Clinical Governance Groups

- Lead clinical governance related activity across the division.
- Ensure there are regular meetings of the DCGG, which address safe and effective care.
- Produce a quarterly risk and patient safety report, which is presented to the CGRMG.
- Appropriately escalate matters of concern to appropriate directors and senior managers.
- Support the divisional Clinical Governance Leads towards the management of actions required to address outstanding clinical governance issues.

5.0 Implementation

5.1 The strategy will be implemented via the following mechanisms and is graphically represented at Appendix E.

a) ***Clinical Governance Committee (CGC).*** Formal arrangements exist for the Board to discharge its responsibility for clinical quality through the CGC.[4] The purpose of the CGC is to oversee and monitor the implementation of the safe and effective elements of this strategy and to ensure that necessary systems and structures to deliver clinical governance are in place *(see Terms of reference at appendix A).*

b) ***Person Centred Committee (PCC).*** The PCC is in place to scrutinise the delivery of all person centred activity across the Board from both a staff and service user perspective.

c) ***Clinical Governance and Risk Management Group (CGRMG).*** Chaired by the Chief Executive, this group exists to ensure that clinical governance process and structure is in place across the Board and the quality ambitions are delivered across the Board. The CGRMG steers the implementation of clinical governance at an operational level and also acts as the Board's clinical effectiveness committee and has a specific remit to develop and encourage clinical effectiveness activity *(see terms of reference at appendix B).*

d) ***Involving People Group (IPG).*** The IPG takes a lead role in developing robust structures and processes to develop and embed the principles of PFPI and equality and diversity across the Board as outlined in the **Involving People Strategy.** Again, this group is managed and administered by staff from the CGD to ensure synchronisation of activity and consistent sharing of information with the CGRMG.

e) ***Clinical Governance Department (CGD).*** The CGD will organise and co-ordinate appropriate multi professional activities to support staff in delivering and developing clinical governance within the GJNH. The CGD will also provide support relating to risk management, clinical effectiveness, involving people and equality and diversity. The CGD will also source external expertise where this is required. Other short life working groups may be developed as required to steer development of areas of clinical governance.

f) ***Divisional Clinical Governance Groups (DCGGs).*** DCGGs are established to support all divisional staff to discuss all elements of clinical governance through formal meetings. These groups will also monitor progress with local activity based around the remit of the CGD. Members of the CGD will attend these groups in order to provide advice and share learning across the divisions. These meetings will complement not replace existing team meetings *(see terms of reference at appendix B).*

g) ***Corporate Clinical Governance Group (CCG).*** A forum for all corporate heads of function (including representation from the Beardmore Hotel and

[4] See NHS MEL (2000) 29

Conference Centre) to meet on a quarterly basis to discuss relevant risk and incident data and to share learning laterally with divisions were this is appropriate.

h) ***Specialist Groups and Committees.*** A number of groups and committees have a key role to play in the delivery of clinical governance. The CGRMG oversees the activity of these groups and provides support and advice as is appropriate and may commission them to undertake relevant pieces of work as necessitated by local or national priority. Specialist Groups and Committees provide an annual report and work plan to the CGC and progress of delivery of this is monitored through the CGRMG. A list of current Specialist Groups and Committees can be viewed on the governance arrangements chart in appendix E.

i) ***Local Clinical Forum (LCF).*** The Board's LCF will provide clinical insight and advice on the delivery of this strategy and will deliver specific projects as commissioned by the CGRMG.

j) ***Performance and Planning Committee.*** This group monitors delivery of operational activity related to the Board's HEAT targets and coordinates activity related to the Balance Score Card. As required it will review risks associated with delivery of targets and if appropriate place these on the corporate risk register.

k) ***Senior Management Team (SMT).*** The Board's SMT ensures there are appropriate resources for the delivery of this strategy. Specifically, the SMT ensure risk is appropriately considered and managed across all areas of the Board.

l) ***Quality Patient Public Group (QPPG).*** The QPPG is an advisory group of former patients and members of the public who provide input to a range of quality improvement activity. Although not formally part of the Board's governance arrangements, the QPPG is represented at the CGC to enable its perspective to be shared.

6.0 Monitoring

6.1 Implementation will be monitored in the following ways:

a) ***Robust Reporting***. The CGC and PCC will publish an annual schedule of reports, which will cover all aspects of this strategy. The DCGGs, CGRMG and IPG will ensure reports are completed and reviewed prior to submission to the relevant committee. In this way, there will be assurance to the Board that the key elements of this strategy are being delivered at operational level and scrutinised by relevant committees.

b) ***Quality Scheme***. An annual quality scheme will be published. The Quality Scheme outlines the progress that has been made in the delivery of all

elements of this strategy but with specific attention on the core quality ambitions. The Quality Scheme will also outline key improvement actions, which will support ongoing delivery of this strategy.

c) ***Internal Audit***. As agreed with the Board's internal auditors specific aspects of this strategy will be audited on an annual cycle and appropriate improvement plans developed.

d) ***Bi Annual Survey***. The CGD will conduct a bi annual survey to establish the effectiveness of implementation of this strategy.

e) ***Component Specific Review.*** On a periodic basis, all elements of this strategy will be reviewed to assess their effectiveness.

7.0 Communication

a) Communication for clinical governance will follow the principles and process outlined in the Board's **Communication Strategy**.

b) The CGD will continue to develop both internet and intranet sites providing a portal for all staff, patients and service users to access clinical governance related information. The CGD will also utilise appropriate newsletters to update on activity.

c) Minutes, reports and all appropriate documentation from the activities of the CGRMG and CGC will be published on both the intranet and internet.

d) All meetings of the above groups and committees are open to all staff.

8.0 Review

This strategy will be reviewed on a three yearly basis by the CGRMG with subsequent ratification sought from the CGC.

Appendix A

ToR Clinical Governance Committee.

TBI

Appendix B

Terms of reference

Clinical Governance and Risk Management Group (CGRMG)

1.0 Introduction

The primary responsibility for the delivery of clinical governance and quality initiatives sits within Divisional Management Teams (DMT), Divisional Clinical Governance Groups (DCGGs) and ultimately with staff. The following groups provide the support structure for clinical governance:

- The daily 'operational' business of clinical governance is supported by the Clinical Governance Department (CGD).

- The coordination and leadership for development of clinical governance at divisional level is through the DCGGs with support and advice provided through specialist groups and committees.[1]

- The CGRMG provides oversight of clinical governance across the Golden Jubilee National Hospital (GJNH) providing assurance to the Board's Clinical Governance Committee (CGC) that safe and effective care and services be delivered across all areas of the Board including the Beardmore Centre for Health Science and the Beardmore Hotel and Conference Centre.

- The Involving People Group (IPG) has specific focus on implementing the Involving People Strategy and provides reassurance of this to the Person Centred Committee.

2.0 Remit of the CGRMG

The overarching objective of the CGRMG is to ensure that care and services are safe and effective and that risks from all areas of the Board are managed and escalated appropriately. The CGRMG will:

1. Oversee the delivery of the Board's clinical governance and risk management strategies and appropriate action plans. In doing so, it will ensure that there are fit for purpose reporting structures which are reviewed for effectiveness on an annual basis. Progress action plans at all meetings.

2. Ensure there is a Risk Management Strategy in place, which clearly defines responsibilities, and risk management objectives for the Board and that these are delivered.

[1] See Governance Structure at Appendix E

3. Be generally aware of the Board's risk profile through scrutiny of the corporate risks. Specifically, to assist and advise the Senior Management Team (SMT) to maintain a corporate risk register, which will ensure the Board focus on key prioritised risks and the action implemented to address such risks.

4. Oversee the development, implementation, monitoring and review of the Board's Business Continuity cycle.

5. Review and provide final approval for all Incident Reviews (IR) (*see the Board's Incident Reporting Policy for full details).*

6. Review on a quarterly basis, risk and patient safety reports from both divisions.

7. Review all major incidents which have been subject to route cause analysis (RCA) prior to their submission to the Board and ensure action plans are in place for such events and that these are delivered against agreed timescales (*see the Board's Incident Reporting Policy for full details).*

8. Monitor health & safety action plans and addressing of risks and risk alerts.

9. Ensure that DCGGs are leading clinical governance activity across divisions. Outputs will be monitored through scrutiny of agreed reports, principally the risk and patient safety report.

10. Ensure there is a Clinical Improvement Policy in place, which clearly defines responsibilities and clinical effectiveness and improvement objectives. The CGRMG will ensure there is an annual clinical audit and improvement plan in place, informed by activity from both divisions, as well as corporate functions, and monitor its delivery.

11. Ensure there is active participation of group members in NHS Healthcare Improvement Scotland (NHS HIS) reviews. This includes completion of self-assessment of NHS HIS standards or providing information for other peer reviews. In addition, ensuring appropriate remedial plans in place to meet shortcomings from peer reviews and / or national reports (recommendations from fatal accident enquiries etc.) and monitor the delivery of these plans by appropriate clinical leads and associated groups and committees.

12. Liaise with the SMT and Performance and Planning Committee to ensure relevant information and ideas are exchanged between these forums to enhance the delivery of safe and effective care and services.

13. Provide leadership and direction to resolve issues which directly or indirectly affect the delivery of safe and effective care and which cannot be resolved at divisional level.

14. Monitor activity and outputs of all specialist groups and committees to ensure work plans are being delivered. Minutes of meetings are required to be sent to the Head of Clinical Governance and chairs of such groups and committees will be required to provide exception reporting on a quarterly basis related to annual work plans.

15. Ensure wide communication of clinical governance and risk management strategies through training/ media /communication etc. to develop an evaluation process and staff involvement.

16. Provide the CGC with appropriate reports as guided by the committee's schedule of reports.

17. Support and champion the Board's approach to a fair and open culture and reviewing the progress of embedding this.

18. Agree and coordinate a scheme of delegation annually.

19. Approve all Board wide policies and strategies linked to clinical governance and risk management activity.

20. Whilst the IPG will oversee implementation of the Involving People Strategy and associated actions the CGRMG will liaise appropriately with the IPG to ensure risk and effectiveness activity is appropriately informed by its agenda.

3.0 Membership

The membership of the group is highlighted below.

Members

Chief Executive (Chair)
Nurse Director (Vice Chair) (Executive lead for CG&RM)
Medical Director (Executive lead for CG&RM)
Director of HR
Head of eHealth
Director of Finance
Director of Business Services
Head of Operations for Surgical Services
Head of Operations for Regional and National Medicine
Co Chairs from Divisional Clinical Governance Groups
Chair of Local Clinical Forum
General Manager for Beardmore Hotel and Conference Centre
Infection Control Manager
Head of Clinical Governance (Professional Secretary)
Clinical Governance Leads from Clinical Governance Department
Health and Safety Advisor
Clinical Education and Improvement Nurse

In attendance as required

Head of Learning and Development
Chairs of Specialist Groups and Committees
Research and Development Manager

4.0 Responsibilities of Specific Members

(a) Chief Executive. Acts as the chair of the CGRMG and as such is responsible for providing leadership and direction.

(b) Vice Chair. Will be the Nurse Director (or Medical Director in their absence) and will support the chair in their duties. Where the chair is absent from meetings the vice chair will act as their deputy.

(c) Head of Clinical Governance. As professional secretary to the group, is responsible for coordination of all its activity. This individual will be required to:

- Ensure meetings are arranged to maximise attendance;
- Along with Chair / Vice Chair, set agendas for meetings;
- Ensure reports for the CGC, as directed by its schedule of reports, are completed.

(d) ***All members.*** All those who are members of the CGRMG are expected to attend meetings regularly and prepare appropriately for meetings.

5.0 Meetings

The CGRMG will meet approximately six weekly. Dates will be planned annually by the CGD. To ensure appropriate feedback to members who are unable to attend a list of action points will be circulated no less than one week after a meeting. Queries will be addressed by the Head of Clinical Governance or by an appropriate member of the group who attended.

Quorum. *For a meeting to be quorate the following must be present:*

- Chair or Vice Chair; and

- Seven other members of the group.

Administration for meetings will be provided through the CGD.

6.0 Agenda

A fixed agenda will be used however, given the potential size of the agenda there should be flexibility around prioritising items. Production of the final agenda will rest with the Chair / Vice chair. Decisions around prioritisation will be influenced by:

- Local or national issues, which have an immediate impact on clinical care and / or staff or patient safety.

- Local or national issues which have an immediate impact on external peer review updates as relates to the preparations for such reviews.

- Scrutiny of outputs from Steering Groups and Specialist Groups and Committees.

- Policy, procedure and guideline reviews.

- Updated reports for DCGGs / Health & Safety / Corporate.

Agenda items will be called for two weeks prior to meeting with agenda and papers issued seven days prior to meeting.

7.0 Disseminating Information to Staff

The CGRMG recognises the importance of ensuring staff are fully appraised of its activities and milestones in the development and embedding of clinical governance throughout the Board. Therefore, all staff will:

- Be able to attend meetings as observers. This will be through agreement and support of the Chair / Vice Chair/ Head of Clinical Governance.

- Be able to raise issues relating to clinical governance (and represent them as appropriate) either:

    - Through DCGGs
    - Through the Head of Clinical Governance, as appropriate.

- Be able to view minutes of meetings and action plans on the local intranet.

- Papers are available on request.

8.0 Reporting Arrangements

The CGRMG reports to the CGC and will ensure that all relevant reports as outlined in its schedule of reports are complete and submitted by agreed timescales.

An annual report will be prepared for the Board on all clinical governance activity and outcomes of external monitoring visits.

9.0 Review

These terms of reference will be reviewed as part of the review of this strategy.

Date of version: May 2013
Appendix C

Terms of reference

Divisional Clinical Governance Group (DCGG)

1.0 Introduction

The primary responsibly for ensuring the delivery of clinical governance and quality initiatives sits with the Divisional Heads of Operations and Associate Medical Directors. Delivery on an operational level is devolved to all staff and led by Medical Governance Leads, senior nursing and healthcare professionals.

DCGGs are the established means by which each division can oversee the development, implementation and ongoing review of a programme of clinical governance and quality objectives, which lead to continuous clinical quality improvement across its specialties.

2.0 Remit of the DCGG

The overarching objective of each DCGG is to ensure that care and services within the division are safe, effective and person centred and that risks that may affect this are managed and escalated appropriately. This is achieved through ensuring divisional staff contribute appropriately to the delivery of the Board's Clinical Governance Strategy and Quality Scheme. To achieve this, the DCGG must provide visible leadership and direction to divisional staff in order to resolve issues, which directly or indirectly affect the delivery of safe and effective care.

Specifically, each DCGG will:

1. Ensure the division and its associated clinical specialties has in place a quality and clinical governance work plan with clear objectives and oversee the delivery of this. Progress with work plans will be reviewed on an exception basis at each meeting.

2. Scrutinise the divisional clinical dashboard. Where indicators fall out of agreed limits, the DCGG will ensure actions are in place to restore these quickly and efficiently.

3. Ensure the Board's Risk Management Strategy is implemented. Specifically:

    a. Ensure that mortality and morbidity data is collected and utilised to ensure that patient care is safe and effective and that agreed mortality rates are achieved. The DCGG will ensure a robust structure and process is in place to allow this to occur and that

outcomes and analysis is reported appropriately to the Clinical Governance and Risk Management Group (CGRMG).

b. Ensure that risk registers are managed proactively across all wards and departments within the division and these contribute to the Board's risk profile using appropriate escalation.

c. Ensure that incidents and near misses are reported and managed in a timely and effective way and appropriate learning plans are in place and delivered, where this is required.

d. Support the management and investigation of complaints in an appropriate way so that these are closed against agreed national 20-day timescales.

e. Contribute to all investigations related to all major incidents, which are undergoing route cause analysis (RCA).

f. Ensure that the division adheres to the Board's Business Continuity structure and the division manages major incidents and service disruptions in an effective and appropriate way.

4. Oversee delivery and monitor outcomes of quality and safety improvement indicators (such as those linked to the Scottish Patient Safety Programme (SPSP) and Clinical Quality Indicators (CQIs)) as appropriate to the activity of the division.

5. Ensure the division implements the effectiveness / quality improvement element of the Board's Clinical Governance Strategy. There should be an agreed annual programme of audit and improvement activity, which is reported to the Audit Committee on a quarterly basis.

6. Ensure completion of relevant Healthcare Improvement Scotland (HIS) self-assessments against clinical standards and projects as appropriate to the business of the division. The DCGG will also ensure that following such reviews, where challenges are identified, there are appropriate remedial plans in place to meet these.

7. Identify training requirements for staff for all elements of clinical governance and quality. The division will work with the Clinical Governance Department and Learning and Development to ensure appropriate methods of delivery ensuring staff are equipped to deliver the agenda effectively.

8. Provide the CGRMG with a quarterly risk and safety report, using the agreed format, which will provide assurance of the delivery of safe and effective care.

9. Support and champion the Board's approach to a fair and open culture ensuring the Board's vision and values are embedded into practice.

3.0 Membership

The membership includes a representative from each of the areas within the Division i.e. nursing, medical and allied health professional groups. There is also membership from those who cross both divisions, as and when required e.g. Theatre Manager, Chief Pharmacist, Head of Medical Physics, and Clinical Nurse Managers.

4.0 Responsibilities of Specific Members

(a) Lead clinician. Act as co chair of the DCGG and as such is responsible for providing leadership and direction about clinical governance issues within the clinical team.

(b) Lead nurse. Act as co chair of the DCGG and as such is responsible for providing leadership and direction about clinical governance issues within the clinical team.

(c) Head of Clinical Governance / Senior Clinical Governance Lead / Clinical Governance Lead. Will be expected to provide relevant advice and support to allow the DCGG to function to deliver its remit. These individuals will be required to:

- Facilitate and support meetings to ensure their smooth running.
- Provide advice to co chairs on current issues when setting agendas for meetings.

- Support the DCGG co chairs in compiling the quarterly clinical governance report for CGRMG.

- Coordinate the daily Clinical Governance Department activity so that it supports the work of the division.

(d) All members. All members of the DCGG are expected to attend and actively participate in meetings.

5.0 Meetings

The DCGG will normally meet at least 10 days prior to the CGRMG. Clinical governance staff will undertake to publish CGRMG meetings annually so allowing the DCGGs to plan their meetings accordingly.

Quorum. *For a meeting to be quorate the following should be present:*

- Either Co Chair; and

- Eight other members of the group including a minimum of two members of medical staff.

Administration for meetings will be provided by a Clinical Governance Assistant. In the absence of a Clinical Governance Assistant, the co chairs will be asked to provide administrative support from their division.

6.0 Agenda

A fixed agenda will be used however, given the potential size of the agenda there should be flexibility around prioritising items. Production of the final agenda will rest with the co chairs. Decisions around prioritisation will be influenced by:

- Local or national issues, which have an immediate impact on clinical care and / or staff or patient safety.
- Local or national issues that have an immediate impact on external peer review as relates to the preparations for such reviews.
- Scrutiny of outputs from Steering Groups and Specialist Groups and Committees.
- Policy, procedure guideline reviews.
- Updated reports for DCGGs / Health & Safety / Corporate.

Agenda items will be required two weeks prior to meeting with agenda and papers issued by the clinical governance department at least seven days prior to a scheduled meeting.

7.0 Disseminating Information to Staff

The DCGG recognises the importance of ensuring staff across specialties are fully appraised of its activities and milestones in the development and embedding of clinical governance and quality throughout the division. Therefore, all staff will:

- Be able to attend meetings as observers. This will be through agreement and support of the Co Chairs / Head of Clinical Governance.
- Be able to raise issues relating to clinical governance through their wards and departments and where appropriate escalate these to the DCGG.
- Be able to view minutes of meetings and action plans on the staff intranet. Papers are available on request.

8.0 Reporting Arrangements

The DCGGs report to the CGRMG and will ensure that all relevant reports, as outlined in the Clinical Governance Committee's schedule of reports, are complete and submitted by agreed timescales.

9.0 Review

These terms of reference will be reviewed annually.

Date of version: July 2013

Appendix D

Historical Context to Clinical Governance

Background and definition

The 1999 Health Act placed a statutory duty on the NHS to provide quality care for patients. This was supported in England and Wales through Health Service Circular (HSC) 1999 / 065 – Clinical *Governance in the new NHS,* which provided advice and support on implementation on a very broad level for NHS Trusts.

In Scotland, the Scottish Office (Department of Health) indicated its intention to develop the clinical governance agenda in 1998 with the publication of *MEL* [1] *(1998) 75*, this document complemented the white paper *'Designed to Care'* and highlighted the legal requirement for all Trusts and Boards in Scotland to have in place systems of clinical governance as well as guidance in how to set in place such a framework. This framework was required to be in place by April of 1999.

The Scottish Executive Health Department (SEHD)[2] followed this with the publication of *MEL (2000) 29* and *HDL*[3] *(2001) 74* which provided further guidance on implementing the clinical governance framework and reinforced the Executives commitment to the principles of this framework*. HDL (2001) 74* also reinforced the requirement of Boards and Trusts to have established Clinical Governance Committees to oversee clinical governance related activity. *HDL (2003) 11* placed clinical governance in the context of single system working placing emphasis reinforcing clinical leadership and service redesign.

In 2010, the Scottish Government launched its national Quality Strategy, which singled a commitment to ensure the NHS worked towards becoming a world leader in the delivery of its services through three key ambitions – Safe, Effective and Person Centred. This strategy reflects these ambitions and incorporates them into its clinical governance framework.

[1] MEL – Management Executive Letter
[2] Replaced the Scottish Office (Department of Health) after devolution
[3] HDL – Health Department Letter

Appendix E

Governance Structure

National Waiting Times Centre NHS Board CGRM Structure