The State Hospital
Clinical Effectiveness Strategy & Delivery Plan
January 2011 – December 2013

Version 3: January 2011
Review Date – December 2013
**Introduction**

Clinical governance is a framework through which NHS organisations are accountable for clinical performance. It exists to safeguard high standards of care, and provide an environment in which excellence can flourish.

Clinical governance is a complex activity with many elements, strategies and initiatives to support patient safety and quality improvement. As shown in Figure 1, clinical effectiveness is one of the key components of clinical governance.

**Figure 1 – The Components of Clinical Governance**

Clinical effectiveness can be defined as the extent to which specific clinical interventions achieve what they are intended to achieve. Decisions to develop and provide services should be driven by evidence of both clinical and cost effectiveness.

In practice, clinical effectiveness is about developing and delivering high quality care. Ideally, this should involve using the best available research evidence, together with clinical expertise and patient involvement. Sometimes within the field of mental health (and forensic mental health in particular) there is a limited evidence base. In these cases, clinical effectiveness can be achieved through benchmarking, audit, and continuous improvement based on identifying and sharing good practice.

The State Hospital's clinical effectiveness agenda is influenced by a range of national standards and strategy, including:
- The Healthcare Quality Strategy for NHS Scotland
- NHS QIS Clinical Governance and Risk Management Standards
- NHS QIS Schizophrenia Standards
- NHS QIS Learning Disability Standards
The Healthcare Quality Strategy for NHS Scotland published in May 2010 includes 3 Quality Ambitions shown in the diagram below:

These 3 Quality Ambitions will provide the focus for all our activity to support our aim of delivering the best quality healthcare. They are based on the internationally recognised six dimensions of healthcare management (Institute of Medicine):

- Person centred
- Safe
- Effective
- Efficient
- Equitable and
- Timely

The State Hospital also has a number of local strategies that influence the clinical effectiveness agenda. These include:

- Local Delivery Plan
- Clinical Governance Strategy
- Clinical Model

The Hospital is committed to working in partnership with the public and patients / carers. Therefore it is important to see the Clinical Effectiveness Strategy in the context of a wider approach to patient focus and public involvement. The methods for
achieving this are set out in the Patient Focus and Public Involvement (PFPI) Strategy and action plan.

The Clinical Effectiveness Strategy is further supplemented by:
- Integrated Care Pathways (ICP) Strategy
- Research Strategy

**Purpose of the Clinical Effectiveness Strategy**

The State Hospital’s Clinical Effectiveness Strategy sets out the objectives required to deliver clinical effectiveness across the organisation. The Clinical Effectiveness Strategy, along with the Risk Management Strategy, directly underpins the delivery of the hospital’s Clinical Governance Strategy.

Implementation of the Clinical Effectiveness Strategy will assist the organisation in embedding the principles of continuous improvement and quality assurance through all of its operations. It has been developed with due consideration to the hospital’s commitment to increasing compliance with the NHS Quality Improvement Scotland Clinical Governance & Risk Management Standards.

**Aims of the Strategy**

- To underpin a culture of quality within the organisation
- To create the context in which quality improvement practices are embraced
- To promote the development of key skills and capabilities to evaluate and review health care services
- To develop the organisational capacity to embed continuous improvement in clinical teams and professional groups.
- To improve outcomes for patients.

**Clinical Effectiveness Objectives: A Framework for the State Hospital**

There are four key Clinical Effectiveness objectives for improving quality across the organisation:

- Increase the proportion of care that is evidence-based and which is known to be clinically and cost effective (e.g. guidelines, standards, best practice statements) and based on patients’ needs. This will be delivered through ensuring that a system is in place to prioritise, implement, monitor and review national guidance and standards.
- Identify variations in clinical outcomes (e.g. through clinical effectiveness projects and ICPs) and develop approaches to improve the quality of care ensuring that clinical effectiveness and quality improvement activity is patient and carer focussed.
- Support a quality culture by developing staff competencies in monitoring, reviewing and ultimately improving practice.
- Embed the principles of clinical effectiveness and continuous quality improvement by developing and implementing strategies, policies, structures and programmes within the organisation to enable improvements in care.
Appendix 1 provides more detail on some of the activities that support each of these objectives.

**Roles and Responsibilities**

The Medical Director is ultimately accountable to the Board for clinical effectiveness, although the Clinical Effectiveness Team works within the Finance and Performance Directorate (Appendix 2). Additionally, each Clinical Director has a responsibility to encourage and monitor clinical effectiveness activity within their respective disciplines and the General Manager is responsible for embedding best practice within operational service delivery.

The principles of clinical effectiveness apply to everyone engaged in the delivery of health care at the State Hospital. It applies not only to State Hospital staff, but also to independent contractors, and students on hospital placements.

The Hospital encourages local ownership of clinical effectiveness, with each department and clinical team responsible for ensuring that activities are systematically monitored and reviewed to achieve optimal performance. As part of this, it is important to involve patients and carers, who can share their own expert views on a wide range of issues relating to the quality of care provided to them. Where clinical effectiveness activities identify areas for improvement, these must be addressed in committee, departmental and clinical team action plans. This process can be supported by the Clinical Effectiveness Department as required.

The Hospital strives to provide a supportive structure for all those involved in clinical effectiveness.

**Implementation**

The Hospital Management Team has a standing agenda section devoted to Clinical Governance, and this is one of the primary means for operational implementation of clinical effectiveness. It is supported in this by the existence of a range of specialist committees each of which have delegated authority for implementation of agreed strategies, policies and plans:

- Mental Health Practice Steering Group
- Physical Health Steering Group
- Medicines Committee
- Infection Control Committee
- Clinical Systems Management Group
- Food Fluid and Nutritional Standards Group
- Clinical Standards Group

Where there are competing demands on resources, the Hospital Management Team has a role to play in prioritising efforts. Where there is a demand for clinical effectiveness activity which cannot be met within current resources a funding bid would be prepared and considered by the Senior Management Team and when supported this would be included in the Local Delivery Plan and supporting financial plan.

The Clinical Effectiveness Strategy will be made available to all staff within the organisation via the hospital’s intranet site. Clinical directors and senior managers will be asked to cascade the strategy to relevant members of their respective teams.

Two way communications are essential to ensure that best practice is being followed. Directors and line managers are responsible for putting in place feedback mechanisms.
whereby clinical effectiveness issues can be discussed within their team. The Hospital Management Team and specialist committees will put in place communication mechanisms to encourage and support the development and implementation of best practice. Through established patient focus and public involvement mechanisms, feedback from patients and carers is actively sought and acted upon. The 4Cs system is well established as a means for gathering information on patients' satisfaction with services received.

Clinical effectiveness systems and tools will be used to progress a range of activities relating to the Local Delivery Plan. The Clinical Effectiveness Programme of Work outlines the activities currently supported by the Clinical Effectiveness Team. It is recognised that a wide range of additional clinical effectiveness activities are ongoing within the Hospital and it is hoped that a full database can be created of all clinical effectiveness activity.

The Programme of Work will be made available via the hospital's intranet site, and will be updated quarterly.

The Clinical Effectiveness Team contributes to the Clinical Governance Annual Report, detailing progress and challenges across three key areas:

- National Guidelines and Standards
- Clinical Audit
- Integrated Care Pathways

**Monitoring and Review**

The State Hospital is committed to ensuring that all of its processes are systematically monitored and reviewed to facilitate continuous improvement of the care it provides. An EFQM exercise has been undertaken as part of this review (appendix 3).

Continuous improvement is an approach to improving performance through frequent, incremental improvement steps. The continuous improvement approach is endorsed by NHS Quality Improvement Scotland through its Clinical Governance and Risk Management Standards. Developing a culture of continuous improvement across the organisation will ensure the hospital achieves the highest level of performance against these standards.

**Figure 2 – NHS QIS Improvement Cycle**
All hospital groups and departments are expected to monitor and review performance with a view to making improvements to patient care and reporting these to the Clinical Governance Committee.
**Reporting and Governance Arrangements**

Documenting the improvements made, and their effectiveness, is a key part of continuous improvement. Hospital groups will report on their continuous improvement progress through the production of an annual report which will be shared within the organisation and considered by the Clinical Governance Committee. Where the monitoring and review process has identified areas for improvement, each group has a responsibility to ensure that these are prioritised, appropriately addressed and changes reviewed for effectiveness.

Information on the implementation of guidelines and standards, and completed audit work will be routinely reported to the Hospital Management Team (and sub-groups as required), and to the Clinical Governance Committee. Variance analyses from Integrated Care Pathways are reported to clinical teams, professional groups, the Hospital Management Team, and Clinical Governance Committee. Ad hoc reports can also be generated on request.

The Hospitals performance management system is driven by the Local Delivery Plan and supplemented by implementation of clinical team performance reporting provides robust information on outcomes for patients. The true test of clinical effectiveness activity is improved outcomes for patients, through improving their health and wellbeing.

The Clinical Governance Committee has delegated authority from the Board for Clinical Effectiveness. The Clinical Governance Committee will seek to assure the Board that appropriate systems are in place by reviewing clinical effectiveness arrangements in depth on a periodic basis.

The Clinical Governance Committee will carry out an in-depth review at the end of each Clinical Effectiveness Programme of Work. The Clinical Effectiveness Department will review its programme of work through bi-monthly meetings. Any concerns from the regular reviews by the department will be escalated to the Clinical Forum.

NHS QIS will provide assurance on our clinical effectiveness arrangements through a periodic peer review process based on the national Clinical Governance and Risk Management Standards.

**Addressing Areas of Underperformance**

The process of monitoring and reviewing performance may, on occasion, identify areas of serious underperformance or non-compliance with best-practice. The hospital has a range of existing mechanisms that could be triggered should these occur. These include:

- Critical Incident Investigation
- Management of Capability Policy

Usually, however, it is possible to address issues through departmental or group action plans, with a follow-up review scheduled to ensure changes have been effective.
Role of the Clinical Effectiveness Team
The role of the Clinical Effectiveness Team is to support the delivery of the above objectives, in line with national standards and clinical guidelines. A range of continuous improvement methods are used to do this, including:

- Standards and guidance – disseminating national standards and guidance and providing support for assessment of current practice against standards, applicability of standards, and work required to implement relevant aspects.
- Clinical audit – a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit measures and the implementation of changes in practice if needed.
- Integrated Care Pathways (ICPs) – structured processes which outline prescribed care, identify who is responsible for delivery of that care within the multi-disciplinary team and record the delivery of that care. ICPs are used to monitor, co-ordinate and improve the quality of patient care.

A separate, complementary strategy has been developed for Integrated Care Pathways.

The Clinical Effectiveness Team has a supporting role in achieving these organisational objectives – much of the activity will be undertaken by multi-disciplinary teams, and individual professions. The Clinical Effectiveness Team should be notified of all clinical effectiveness activity, even when no direct input is required from the department. This will ensure that good practice can be shared, advice can be given where necessary, and avoid duplication of effort across different areas of the hospital.

Although a great deal of clinical effectiveness activity should be driven by individual teams and professions, the Clinical Effectiveness Team has a lead role in projects identified as organisational priorities. These are detailed in the Clinical Effectiveness Programme of Work.

Format
This document is available in other formats, if required, on request from the Head of Communications.

Review
This strategy will be reviewed by December 2013, or sooner if required.
APPENDIX 1 – Clinical Effectiveness Objectives In Practice

OBJECTIVE 1
Increase the proportion of care that is evidence based and which is known to be clinically and cost effective (e.g. guidelines, standards, best practice statements) and based on patients’ needs. This will be delivered through ensuring that a system is in place to review, prioritise, implement and monitor national guidance and standards.

Ongoing Activity
High quality clinical guidelines, standards and policies support the provision of high quality clinical care by allowing clinicians to rapidly identify effective evidence-based practice and interventions. Effective implementation depends upon effective dissemination and implementation strategies, adequate resources and a supportive culture that enables clinicians to make changes to their routine clinical practice. Research has shown that whilst guideline and standard development is most efficiently undertaken at a national level, implementation is essentially a local activity supported by effective prioritisation of resources, monitoring and feedback.

The Clinical Effectiveness Department will act as a source of information, providing guidance and support to those involved in the development of evidence-based clinical policies and procedures, and by raising awareness of available evidence and national guidance.

The department will continue to be responsible for establishing which publications are relevant to the work of the hospital and disseminating these. Decisions will be taken in conjunction with the hospital’s Clinical Standards Group.

The Clinical Effectiveness Department will maintain its role as the primary focus for all communication with NHS Quality Improvement Scotland (QIS). This includes support for the following elements of the NHS QIS agenda:

- **QIS Review Processes**
  - This role will include facilitating the submission of all self assessment documentation on schedule and to agreed standards of presentation, making logistical arrangements for review visits, keeping staff informed of their required involvement in the review process and maintaining a timetable of associated activities.
  - The Clinical Effectiveness Department will work with the Clinical Standards Group and the lead operational people who are responsible for specific standards. The department will provide guidance on taking the results of the reports forward (e.g. through action planning).
  - Achievement against NHS Quality Improvement Scotland Standards will be monitored routinely through the Clinical Standards Group and annually by the Clinical Governance Committee.

- **Best practice statements**
  - The Clinical Effectiveness Department will maintain a register of these.
  - All best practice statements will be discussed at the most appropriate group
• QIS Comments on NICE guidelines / Health Technology Assessments and Appraisals / Scottish Medicines Consortium product assessments
  o The Clinical Effectiveness Department will maintain a register of these, and will disseminate them as appropriate. They will be published on the clinical effectiveness section of the hospital’s intranet site.

• SIGN guidelines
  o The Clinical Effectiveness Department will maintain a register of these, and will disseminate them as appropriate. The register will be used to record relevance of guidance and compliance.

• Responding to consultations (e.g. standards, best practice statements)

Through representation on hospital groups and committees, clinical effectiveness staff will provide expert advice to ensure that measurable standards are developed for new policies, procedures, and guidelines and that their implementation and effectiveness can be monitored and reviewed in the future.

In instances where the best-practice evidence-base is lacking or is ambiguous, clarification may be sought in conjunction with the Research Committee or Research and Development Manager.

Key Future Developments
• Implement a review process for clinical guidelines and standards to ensure areas for improvement identified through the evaluation process have been addressed and have resulted in improved patient care.
• Develop links with Research & Development Manager to identify, prioritise and increase the evidence base relating to forensic mental health.
OBJECTIVE 2
Identify variations in clinical outcomes (e.g. through clinical effectiveness projects and Integrated Care Pathways) and develop approaches to improve the quality of care ensuring that clinical effectiveness and quality improvement activity is patient and carer focussed.

Ongoing Activity

The department supports this aim through a range of clinical effectiveness projects (including assisting with patient and carer surveys), and Integrated Care Pathways (ICPs).

To ensure that clinical effectiveness projects are implemented appropriately across the hospital a system of prioritising clinical effectiveness projects is in place leading to the identification of key projects. It is based on the following:

- Local priorities such as our Local Delivery Plan and associated strategy documents e.g. Management of Imminent Violence
- Forensic Mental Health Specific e.g. Forensic Network
- Local concerns – projects proposed by individual clinicians falling outwith the identified priority areas may be undertaken.
- National Priorities i.e. mandatory work including NHS QIS clinical standards and other NHS QIS activity, e.g. SIGN guidelines.

ICPs help to improve, monitor and enable review of patient care in particular for the admission, inter-ward transfer and the case review processes. Where appropriate they incorporate national standards thus helping to embed evidence into everyday practice.

ICP variance analysis enables clinicians to reflect on their own practice and make improvements to patient care. Variance analysis reports are discussed within clinical teams, professional departments and management teams. With support from managers, this ensures standards are improved in teams and departments. ICPs are used in all wards, allowing comparisons to be made and facilitating the sharing of good practice.

Close links have been developed between Clinical Effectiveness and Performance Management to support clinical staff to monitor, review and continuously improve levels of patient care.

The attached Programme of Work details both clinical effectiveness and ICP priorities. There is a separate Integrated Care Pathway Strategy which supports this agenda.

Key Future Developments

- Gain next level of NHSQIS Accreditation for Integrated Care Pathways for Mental Health. Accreditation for the process part of the standards was attained in April 2009.
- Explore the role of the ICP Link Nurse in connection with the generic and condition specific standards.
OBJECTIVE 3
Support a quality culture by developing staff competencies in monitoring, reviewing and ultimately improving practice.

Ongoing Activity
The Clinical Effectiveness Department will continue to promote awareness amongst staff of clinical effectiveness and the continuous improvement agenda. They will also ensure that staff are aware of the support, resources and guidance available from the department. Regular updates will be provided via the Staff Bulletin on the latest clinical effectiveness developments.

Clinical Effectiveness staff members provide support, training and guidance for individuals, clinical teams and other groups to ensure they are equipped with the skills needed to monitor and review the services they provide.

- **Formal Approaches to Education**
  - Induction training
  - ICP Link Nurse training
  - Team development training

Formal Clinical Effectiveness educational programmes will be developed in consultation with the Training and development Manager as required.

- **Informal Approaches to Education**
  - Provide direct advice and support to individuals/groups involved audit projects, performance monitoring and ICP work.
  - Directly support and assist with specific clinical effectiveness projects
  - Promoting awareness of clinical effectiveness in other appropriate groups and forums, locally and nationally.
  - Opportunistic discussions and interactions

**Key Future Developments**
- The Clinical Effectiveness Department will deliver formal clinical audit training based on the Healthcare Quality Quest Clinical Audit package.
OBJECTIVE 4
Embed the principles of clinical effectiveness and continuous quality improvement by developing and implementing strategies, policies, structures and programmes within the organisation to enable improvements in care

Ongoing Activity
The Clinical Effectiveness Team has finite resources, and as such it cannot be given sole responsibility for all clinical effectiveness activity. The department therefore aims to promote and create the culture, context, capabilities and capacity to allow individual clinical teams and departments to take forward their own clinical effectiveness agendas. The Clinical Effectiveness Team is available to provide expert advice and support as required.

As part of this aspiration, Clinical Effectiveness staff participate in a range of strategic and operational groups. The purpose of this is fivefold:

- To ensure the delivery of patient centred care.
- To ensure that new hospital initiatives and programmes are developed in ways that incorporate systems for monitoring and review.
- To ensure that guidelines and national standards are utilised in developing new services, and in reviewing existing services. Where evidence of best-practice is lacking, clinical effectiveness can liaise with the Research and Development Manager to record this as a possible area for further study.
- To ensure that collected data is used to generate actions for improvement. Where there is a lack of data/information clinical effectiveness can liaise with the Performance Manager to develop appropriate indicators to monitor and promote areas of organisational interest.
- To provide expert advice on establishing and using review mechanisms such as clinical audit, and ICP variance analyses.

Key Future Developments
- Working with Hub Managers in new hub and clusters to integrate more with teams and support each team in having a ‘live’ action plan that reflects the priorities for service development and improvement.
## APPENDIX 3 – EFQM Excellence Model applied to Clinical Effectiveness

### Structures

#### Leadership
- Governance accountability
- Annual reporting to Board
- Annual reports to Clinical Governance Committee
- Management reporting
- Reports to Mental Health Practice Steering Group, Medicines Committee & Physical Health Steering Group
- Reports to HMT
- Reports to other commissioning groups (HAI, Infection Control, PFPI, CRDPG)
- Individual responsibility
- Executive lead
- Operational lead
- CE department roles
- ICP Link Nurses

#### Resources for staff
- Central team
- Team meetings
- KSF outline and PDP reviews
- Organisation wide
- Clinical audit training
- ICP Link Nurse training
- Cascade learning
- Staff support mechanisms

#### Policy and Strategy
- Local documents
- Clinical Effectiveness Strategy
- ICP Strategy
- National documents
- NHS QIS standards

#### Partnerships
- Internal
- Clinical teams
- Performance Mgt
- Steering Groups
- External
- POMH audits
- NHS QIS Networks

### Processes

#### Resources for staff
- Routine
- Commissioned through steering group
- Commissioned through PFPI, Infection Control and CRDPG
- Project planner completed for all new audits
- Audit planner completed
- Register on audit database with hyperlink to reports and action plans
- Re-audit to evidence continuous improvement

#### Policy and Strategy
- Exceptions
- Audits commissioned by Board

#### Partnerships
- System maintenance and development
- Clinical Effectiveness programme of work

### Outcomes

#### Patient Results
- Perception
- Improvement in patient care
- Indicators
- Number of recommendations that have been implemented.
- Re-audit results
- Patient Survey

#### Staff Results
- Perception
- Improvement to patient care
- Systems that are robust and consistent
- Indicators
- Staff participation
- Changes to systems

#### Society Results
- LDP outcomes
- Audit of Treatment, Access and Health Targets
- CE Strategy outcomes
- Increase the proportion of care that is evidence based
- Identify variations in clinical outcomes
- Support a quality structure through monitoring, reviewing and ultimately improving practice
- Embed the principles of clinical effectiveness and continuous quality improvement
- Top level KPIs
- Programme of work is met
- Re-audits show improvements
- Public reporting
- Clinical Governance Annual Report
- Steering Group Annual Reports
Clinical Teams

Departments and Services

Clinical Governance Committee

Mental Health Practice Steering Group
Food, Fluid and Nutrition Group
Clinical Teams

Physical Health Steering Group
Clinical Standards Group
Departments and Services

Examples...

Operational Reporting / Management Reporting

Governance Reporting

Clinical Effectiveness Activity Undertaken by Hospital Groups, Departments and Services

APPENDIX 4 – Implementation and Monitoring of Clinical Effectiveness Issues
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Target/Outcome</th>
<th>Source</th>
<th>Projected Completion by</th>
<th>Quality Dimension(s)</th>
<th>Clinical Effectiveness Lead</th>
<th>Organisational Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify, appraise and implement new NHS QIS Clinical Guidelines, standards and best practice statements for both mental and physical health problems</td>
<td>The proportion of care that is evidence based is increased.</td>
<td>Clinical Governance Strategy PHSG Action plan</td>
<td>-</td>
<td>Safe Effective Equitable</td>
<td>Head of Clinical &amp; Risk Governance</td>
<td>Risk Register 1.1</td>
</tr>
<tr>
<td>Assist with all self-assessment and peer review exercises</td>
<td>Self assessments accurately reflect the service we deliver.</td>
<td>NHS QIS</td>
<td>-</td>
<td>Safe Effective Efficient Equitable Timely</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Delivery Plan 11.6</td>
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<tr>
<td>• Clinical Governance &amp; Risk Mgt</td>
<td>Self assessment exercises are submitted timeously.</td>
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<td>• Food Fluid and Nutritional Care</td>
<td>External peer reviews conducted efficiently and effectively.</td>
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<td>• Healthcare Associated Infections (HAI)</td>
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<td>• Dental Services</td>
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<td>• Pandemic Flu</td>
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<td>• Scottish Health Council PFPI</td>
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<td>• Care Standards for Forensic Mental Health In-patient services</td>
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<tr>
<td>Assisting in developing, implementing and evaluating action plans for national guidelines and standards including:</td>
<td>Action plans reflect identified weaknesses and are used as vehicles to improving the quality of patient care/services.</td>
<td>NHS QIS</td>
<td>-</td>
<td>Safe Effective Efficient Equitable Timely</td>
<td>Head of Clinical &amp; Risk Governance</td>
<td>Local Delivery Plan 11.6</td>
</tr>
<tr>
<td>• Schizophrenia</td>
<td>Progress is monitored and reviewed at regular intervals.</td>
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<td>• Infection Control</td>
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<td>• Learning Disabilities</td>
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<td>• Food, Fluid and Nutrition</td>
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<tr>
<td>• Clinical Governance and Risk Management</td>
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<tr>
<td>• Diabetes</td>
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<td>• Healthcare Associated Infections (HAI)</td>
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<tr>
<td>• National ICP standards</td>
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<tr>
<td>Development of ICPs incorporating NHS QIS Standards for ICPs in Mental Health</td>
<td>ICPs in place for Generic pathway ICP ‘slot-ins’ in place for condition specific pathways</td>
<td>NHS QIS Standards for Mental Health</td>
<td>Dec 2011</td>
<td>Safe Effective Equitable</td>
<td>ICP Facilitator</td>
<td>National Priority</td>
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<td>ICP Facilitator National Priority</td>
<td>NIQ Standards for Mental Health ICPs</td>
<td>April 2012</td>
<td>Safe Effective Equitable Timely</td>
<td>ICP Facilitator</td>
<td>National Priority</td>
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<tr>
<td>Development of electronic integrated documentation</td>
<td>Accreditation of ICPs</td>
<td>NHS QIS Standards for Mental Health ICPs</td>
<td>Orthodox</td>
<td>Safe Effective Equitable Timely</td>
<td>ICP Facilitator</td>
<td>Local Priority</td>
</tr>
<tr>
<td>One integrated electronic document incorporating Treatment Plan, HCR-20 &amp; ICP</td>
<td>NHS QIS Standards for Mental Health ICPs</td>
<td>Dec 2013</td>
<td>Safe Effective Equitable Timely</td>
<td>ICP Facilitator</td>
<td>Local Priority</td>
<td></td>
</tr>
</tbody>
</table>
Identify variations in practice (e.g. through clinical effectiveness projects and ICPs) and develop approaches to improve the consistency of care.

<table>
<thead>
<tr>
<th>Audits</th>
<th>Objectives</th>
<th>Target/Outcome</th>
<th>Source</th>
<th>Projected Completion by</th>
<th>Quality Dimensions</th>
<th>Clinical Effectiveness Lead</th>
<th>Organisational Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit looking at monitoring regime of patients on mood stabilisers</td>
<td>To ensure that monitoring guidelines are being adhered to</td>
<td>Medicines Committee</td>
<td>Dec 2011</td>
<td>Safe Effective</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Medicines Committee</td>
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<tr>
<td>Fresh Air Audit</td>
<td>Patients are getting the opportunity to access fresh air daily</td>
<td>Mental Health Practice Steering Group</td>
<td>August 2011</td>
<td>Effective Equitable</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Delivery Plan 3.6</td>
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<tr>
<td>Blood Borne Virus Risk Assessment Audit</td>
<td>Ensure that all patients have the opportunity to have their BBV status checked and also that their risks are assessed at least annually</td>
<td>Patient Partnership Group &amp; Infection Control Committee</td>
<td>February 2011</td>
<td>Safe Equitable</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Delivery Plan 12.8</td>
<td></td>
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<tr>
<td>Patient Property Audit</td>
<td>To ensure systems are working effectively</td>
<td>PPG</td>
<td>December 2011</td>
<td>Patient centred Efficient</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Priority (frequent complaint)</td>
<td></td>
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<tr>
<td>Health Centre Patient Survey</td>
<td>To capture the patients experience of the services delivered by the health centre</td>
<td>PHSG</td>
<td>January 2011</td>
<td>Patient centred Equitable Efficient</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Priority</td>
<td></td>
</tr>
<tr>
<td>Blood Monitoring Audit</td>
<td>To ensure that patients bloods are used for multiple testing</td>
<td>PHSG</td>
<td>January 2011</td>
<td>Safe Efficient</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Priority</td>
<td></td>
</tr>
<tr>
<td>Audit of Falls Procedure</td>
<td>To ensure new pathway is being adhered to</td>
<td>OT</td>
<td>April 2012</td>
<td>Safe Equitable</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Priority</td>
<td></td>
</tr>
<tr>
<td>National PRN Audit</td>
<td>To ensure that patients are not being administered PRN medication unnecessarily</td>
<td>Medicines National Strategy Group</td>
<td>February 2011</td>
<td>Safe Equitable</td>
<td>Clinical Effectiveness Team Leader</td>
<td>National Forensic Priority</td>
<td></td>
</tr>
<tr>
<td>Social Work Audit 1</td>
<td>Tbc</td>
<td>Social Work</td>
<td>September 2011</td>
<td>Tbc</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Priority</td>
<td></td>
</tr>
<tr>
<td>Social Work Audit 2</td>
<td>Tbc</td>
<td>Social Work</td>
<td>September 2012</td>
<td>Tbc</td>
<td>Clinical Effectiveness</td>
<td>Local Priority</td>
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</tr>
<tr>
<td>RE-AUDITS</td>
<td>Description</td>
<td>Date</td>
<td>Team Leader</td>
<td>Group/Leadership</td>
<td>Programme/Plan</td>
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<tr>
<td>Diagnosis Audit</td>
<td>To ensure all systems that capture diagnosis are consistent and robust</td>
<td>June 2011</td>
<td>Safe Equitable Person-centred</td>
<td>Clinical Effectiveness Team Leader</td>
<td>NHS QIS Mental Health ICP standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Worker Attendance Audit</td>
<td>To ensure consistency of systems that capture this information</td>
<td>August 2011</td>
<td>Patient centred</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Delivery Plan 10.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mattress Audit</td>
<td>To identify mattresses in poor condition and bring to the attention of the appropriate person in charge and the Infection Control Committee</td>
<td>Dec 2013</td>
<td>Safe</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Infection Control programme of work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Positive Survey</td>
<td>To capture concerns from staff in relation to their working environment and working relationships</td>
<td>September 2012</td>
<td>Person-centred</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Healthy Working Lives Work Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equality &amp; Diversity Audit</td>
<td>To ensure that the equality and diversity policy is being adhered to</td>
<td>January 2011</td>
<td>Person-centred Effective Equitable</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Delivery Plan 12.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Protection Audit</td>
<td>To ensure that procedures are adhered to with regards to child visits within the hospital</td>
<td>December 2012</td>
<td>Person-centred Effective Equitable</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Delivery Plan 12.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMVA – Nursing Assessment completed for all incidents that require PAA activation</td>
<td>All patients will have a nursing assessment documenting type of holds used</td>
<td>Oct 2011</td>
<td>Safe Equitable Effective</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Risk Register 2.1 / Local Delivery Plan 11.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMVA – Audit of Observation policy</td>
<td>All patients will be observed as per PMVA Observation policy</td>
<td>Oct 2011</td>
<td>Safe Equitable Effective</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Risk Register 2.1 / Local Delivery Plan 11.3</td>
<td></td>
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</tr>
<tr>
<td>PMVA – Audit of all Seclusions</td>
<td>Seclusions are documented as per the PMVA Seclusion policy</td>
<td>Dec 2011</td>
<td>Safe Equitable Effective</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Risk Register 2.1 / Local Delivery Plan 11.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMVA – Audit of physical intervention policy</td>
<td>All incidents where physical intervention is necessary will follow PMVA guidance</td>
<td>Nov 2011</td>
<td>Safe Equitable Effective</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Risk Register 2.1 / Local Delivery Plan 11.3</td>
<td></td>
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</tr>
<tr>
<td>PMVA – Audit of Initial Admission</td>
<td>All patents will have an initial</td>
<td>Nov 2011</td>
<td>Safe</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Risk Register 2.1 / Local Delivery Plan 11.3</td>
<td></td>
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</tr>
<tr>
<td>Risk Assessments</td>
<td>admission risk assessment completed on admission</td>
<td>Equitable</td>
<td>Effectiveness Team Leader</td>
<td>Local Delivery Plan 11.3</td>
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<tr>
<td>PMVA – Audit of Emergency Prescribing</td>
<td>Medicine in the management of violence policy is adhered to</td>
<td>PMVA/Medicines Committee/NHS QIS Schizophrenia</td>
<td>Nov 2011</td>
<td>Safe Equitable Effective</td>
<td>Risk Register 2.1 / Local Delivery Plan 11.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POMH Topic 7: Lithium monitoring</td>
<td>Patients are being monitored as per the evidence based guidance - comparison against other forensic wards in England and Scotland</td>
<td>Medicines Committee</td>
<td>June 2011</td>
<td>Safe Equitable Effective</td>
<td>Clinical Effectiveness Team Leader</td>
<td></td>
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<tr>
<td>POMH Topic 6: The assessment of side effects of depot antipsychotics</td>
<td>Patients side effects should be monitored and acted upon in accordance with guidance - comparison against other forensic wards in England and Scotland</td>
<td>Medicines Committee</td>
<td>June 2011</td>
<td>Safe Equitable Effective</td>
<td>Clinical Effectiveness Team Leader</td>
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</tr>
<tr>
<td>POMH Topic 9 – Use of antipsychotic medication in people with a Learning Disability</td>
<td>To ensure that patients are having their medication reviewed annually and side effects noted where applicable</td>
<td>Medicine Committee</td>
<td>April 2011</td>
<td>Safe Equitable Effective</td>
<td>Clinical Effectiveness Team Leader</td>
<td></td>
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</tr>
<tr>
<td>Audit of T2/T3 following implementation of revised guidelines</td>
<td>All patients will have T2/T3 forms that comply with the guidance from the Mental Welfare Commission</td>
<td>Medicines Committee/NHS QIS Schizophrenia</td>
<td>September 2011</td>
<td>Safe Equitable Effective</td>
<td>Risk Register 1.1</td>
<td></td>
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</tr>
<tr>
<td>Audit of high dose anti-psychotic prescribing guidelines</td>
<td>All patients on high dose received appropriate monitoring of bloods, ECGs and E&amp;Es</td>
<td>NHS QIS Schizophrenia</td>
<td>Feb 2011</td>
<td>Safe Equitable Effective</td>
<td>Local Delivery Plan H.10</td>
<td></td>
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</tr>
<tr>
<td>Audit of the procedure to be followed when a person who has a diagnosis of schizophrenia is admitted to hospital.</td>
<td>Admission procedure followed for all admissions</td>
<td>NHS QIS Schizophrenia</td>
<td>Jan 2012</td>
<td>Safe Equitable Effective</td>
<td>Local Priority</td>
<td></td>
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</tr>
<tr>
<td>POMH Topic 3 re-audit: Prescribing of high dose and combination antipsychotics for patients on forensics wards</td>
<td>No patient, without good reason, will be prescribed about the maximum BNF recommendations - comparison against other forensic wards in England and Scotland</td>
<td>Medicines Committee</td>
<td>April 2011</td>
<td>Safe Equitable Effective</td>
<td>Local Delivery Plan H.10</td>
<td></td>
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</tr>
<tr>
<td>Audit of Lithium Monitoring within the State Hospital</td>
<td>Recommendations from previous audit project are established and monitoring is improved</td>
<td>Medicines Committee</td>
<td>Feb 2011</td>
<td>Safe Equitable Effective</td>
<td>Local Priority</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit looking at completion of treatment plan incorporating the HCR-20 and CPA</td>
<td>All patients will have a concise hospital wide record of their 12 months care for all team members to access</td>
<td>CRAM Group/Mental Health Practice Steering Group (MHPSG)</td>
<td>April 2011</td>
<td>Patient Centred</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Priority</td>
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<tr>
<td>Audit Medicine Fridges within wards and Health Centre</td>
<td>All medicine fridges within the hospital will be fit for purpose and temperature regularly monitored</td>
<td>Medicines Committee</td>
<td>Feb 2011</td>
<td>Safe</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Priority</td>
<td></td>
</tr>
<tr>
<td>Case Note review audit</td>
<td>To ensure professional standards are being adhered to in relation to entries being made in the patients case notes</td>
<td>Clinical Records &amp; Data Protection Group</td>
<td>Ongoing</td>
<td>Safe</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Priority</td>
<td></td>
</tr>
<tr>
<td>Audit of Antimicrobial prescribing</td>
<td>Antimicrobial prescribing will adhere to evidence based guidelines</td>
<td>NHS QIS HAI standards and Medicines Committee</td>
<td>Jan 2011</td>
<td>Safe</td>
<td>Efficient</td>
<td>Local Delivery Plan 5.6</td>
<td></td>
</tr>
<tr>
<td>Audit of Clinical Waste and Sharps</td>
<td>Amount of clinical incidents associated with sharps and clinical waste are reduced</td>
<td>Infection Control Committee</td>
<td>November 2011</td>
<td>Safe</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Infection Control Programme of Work Local Delivery Plan 11.4</td>
<td></td>
</tr>
<tr>
<td>Patient Experience Survey (Annual)</td>
<td>Patients experience is improved, and services are provided in a fair and equitable fashion</td>
<td>PFPI Group &amp; Patient Partnership Group</td>
<td>April 2011</td>
<td>Patient Centred</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Delivery Plan 12.1</td>
<td></td>
</tr>
<tr>
<td>Visitors/Carers Survey</td>
<td>Carers experience is improved, and services are provided in a fair and equitable fashion</td>
<td>PFPI Group &amp; Carers Reference Group</td>
<td>September 2011</td>
<td>Patient Centred</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Delivery Plan 12.1</td>
<td></td>
</tr>
<tr>
<td>Audit of Re-admissions to the State Hospital</td>
<td>To explore reasons for patients being readmitted within 12 months</td>
<td>Mental Health Practice Steering Group</td>
<td>December 2011</td>
<td>Efficient</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Delivery Plan 8.1</td>
<td></td>
</tr>
<tr>
<td>Audit of Admissions to the State Hospital</td>
<td>To ensure that the referrals policy is being adhered to</td>
<td>RMO</td>
<td>October 2013</td>
<td>Efficient</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Priority</td>
<td></td>
</tr>
</tbody>
</table>

**INTEGRATED CARE PATHWAYS**

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Target/Outcome</th>
<th>Source</th>
<th>Projected Completion by</th>
<th>Quality Dimensions</th>
<th>Clinical Effectiveness Lead</th>
<th>Organisational Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit compliance with inter-ward</td>
<td>Revised IWT ICP implemented and</td>
<td>Local</td>
<td>June 2012</td>
<td>Efficient</td>
<td>ICP Facilitator</td>
<td>Local Priority</td>
</tr>
<tr>
<td>Task Description</td>
<td>Details</td>
<td>Time Frame</td>
<td>Aims</td>
<td>Owner</td>
<td>Plan</td>
<td></td>
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</tr>
<tr>
<td>Transfer ICP to ensure transfer is seamless, proactive and patient friendly</td>
<td>Practice follows ICPs, actions identified from variance reports are implemented into practice</td>
<td>Local</td>
<td>Ongoing</td>
<td>Effective, Safe, Patient Centred</td>
<td>ICP Facilitator</td>
<td>Local Delivery Plan 10.4</td>
</tr>
<tr>
<td>Variance analysis of ICPs</td>
<td></td>
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</tr>
<tr>
<td>Develop ICP for patients being discharged/transferred outwith the SH (CPA)</td>
<td>Inclusion of discharge/transfer in ICP patient pathway</td>
<td>NHSQIS Schizophrenia</td>
<td>June 2012</td>
<td>Effective, Safe, Patient Centred, Efficient</td>
<td>ICP Facilitator</td>
<td>Local Delivery Plan 10.8</td>
</tr>
<tr>
<td>Review ICP reporting structure/governance</td>
<td>Regular reporting to management and Board level</td>
<td>NHS QIS Draft Standards for Mental Health ICPs</td>
<td>Jan 2011</td>
<td>Efficient</td>
<td>ICP Facilitator</td>
<td>Risk Register 4.2</td>
</tr>
</tbody>
</table>
Support a learning culture by developing the competencies of staff in evaluating and improving practice.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Target/ Outcome</th>
<th>Source</th>
<th>Projected Completion by</th>
<th>Quality Dimensions</th>
<th>Clinical Effectiveness Lead</th>
<th>Organisational link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance and delivery of induction programmes</td>
<td>All staff are introduced to the Clinical Effectiveness Department (includes ICPs) and its role within the hospital.</td>
<td>Local</td>
<td>Ongoing</td>
<td>Safe Effective Efficient</td>
<td>All</td>
<td>Local Priority</td>
</tr>
<tr>
<td>Provide staff with skills required to undertake clinical audit projects</td>
<td>Clinicians are confident in delivering audit projects with minimal support from the department.</td>
<td>Local</td>
<td>Ongoing</td>
<td>Safe Effective Efficient</td>
<td>Clinical Effectiveness Team Leader</td>
<td>Local Priority</td>
</tr>
<tr>
<td>Explore options to embed clinical effectiveness into multi-disciplinary</td>
<td>Improved multi-disciplinary working with teams being able to audit their practice using PDSA techniques</td>
<td>Local</td>
<td>Ongoing</td>
<td>Safe Effective Efficient</td>
<td>Head of Clinical &amp; Risk Governance / All</td>
<td>Local Priority</td>
</tr>
<tr>
<td>teams</td>
<td></td>
<td></td>
<td></td>
<td>Person-Centred</td>
<td></td>
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</tr>
<tr>
<td>ICP Link Nurse Training/ Forum</td>
<td>Nursing staff / other professions have an understanding of ICPs and their role as ICP link person</td>
<td>Local</td>
<td>Ongoing</td>
<td>Safe Effective Efficient Equitable</td>
<td>ICP Facilitator</td>
<td>Local Priority</td>
</tr>
</tbody>
</table>
Embed the principles of clinical effectiveness and continuous quality improvement through proactive participation in strategic and operational groups across the organisation, and by taking actions at departmental level that strengthen the hospital's overall ability to deliver safe and effective care.

<table>
<thead>
<tr>
<th>Objectives</th>
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<th>Projected Completion by</th>
<th>Quality Dimensions</th>
<th>Clinical Effectiveness Lead</th>
<th>Organisational link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribute to hospital steering groups and subgroups, to ensure due consideration is given to potential clinical effectiveness issues.</td>
<td>Activities and service developments are undertaken in accordance with best practice, and can be regularly monitored and reviewed</td>
<td>Local</td>
<td>Ongoing</td>
<td>Safe Effective Efficient</td>
<td>All</td>
<td>Local Priority</td>
</tr>
<tr>
<td>Contribute to the development of clinical policies and procedures</td>
<td>Staff are informed and guided to the fact that all policies should reflect key components of clinical effectiveness, e.g. they are evidence based, relevant to our population, understandable, measurable and achievable.</td>
<td>Local</td>
<td>Ongoing</td>
<td>Safe Effective Efficient</td>
<td>All</td>
<td>Risk Register 2.3</td>
</tr>
<tr>
<td>Continue to integrate the Clinical Effectiveness Department, Risk Management Department, and Research and Development Department to share knowledge, skills and opportunities for embedding safe and effective care.</td>
<td>Consolidate existing systems, streamline processes and communication between governance departments. Exploit shared opportunities for training. Develop ‘joined-up’ working for monitoring and reviewing risk and clinical effectiveness activities. Identify research opportunities.</td>
<td>Local</td>
<td>Ongoing</td>
<td>Safe Effective Person-Centred</td>
<td>Head of Clinical &amp; Risk Governance</td>
<td>Local Priority</td>
</tr>
<tr>
<td>To develop regular departmental contact with clinical teams.</td>
<td>To use this contact to identify and address training and capacity issues which could impact on their ability to participate in clinical effectiveness.</td>
<td>Local</td>
<td>Ongoing</td>
<td>Safe Effective Efficient</td>
<td>Head of Clinical &amp; Risk Governance</td>
<td>Local Priority</td>
</tr>
<tr>
<td>Review audit reporting templates and processes for implementing actions</td>
<td>Continue to ensure that projects clearly identify the evidence-base that practice is being compared with, the root-causes of systems failures, and the benefits achieved by improvement work.</td>
<td>Local</td>
<td>January 2011</td>
<td>Safe Effective Efficient</td>
<td>Head of Clinical &amp; Risk Governance / Clinical Effectiveness Team Leader</td>
<td>Local Priority</td>
</tr>
<tr>
<td>Provide support for the development</td>
<td>Support the dissemination and</td>
<td>Local</td>
<td>Ongoing</td>
<td>Safe</td>
<td>Head of</td>
<td>National Priority</td>
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</table>
and implementation of emerging national quality improvement initiatives e.g. national Quality Strategy, Mental Health Patient Safety Programme

<table>
<thead>
<tr>
<th>Implementation of national initiatives, developing staff competencies to undertake this is their own operational areas.</th>
<th>Effective</th>
<th>Efficient</th>
<th>Equitable</th>
<th>Person-Centred</th>
<th>Timely</th>
<th>Clinical &amp; Risk Governance</th>
</tr>
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