NHS Greater Glasgow & Clyde

NHS BOARD MEETING

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<tr><td></td><td>**August 2016**</td><td>**Paper No: 16/52**</td></tr>
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Clinical Governance Annual Report 2015-2016

Recommendation:-

The NHSGGC Board is asked to note the content of the NHSGGC Clinical Governance Annual Report 2015-2016 and the clinical governance priorities outlined in the conclusion for the forthcoming year.

Purpose of Paper:-

This report will describe the main governance framework and demonstrate our work to improve the quality of care in our Board through a small selection of the activities and interventions. It is important to note that there is substantially more activity at personal, team, and service level arising from our collective commitment to provide a quality of care we can be proud of. This report can only reflect a small selection so is illustrative rather than comprehensive.

Key Issues to be considered:-

The NHSGGC Clinical Governance Report 2015-2016 is written in the context of substantial organisational change with the establishment of the Health and Social Care Partnerships, the Acute Services Division Management structure reorganisation and the opening of the Queen Elizabeth University Hospital and the new Royal Hospital of Children.

Any Patient Safety /Patient Experience Issues

This report refers to clinical safety, describing the approach to improving safety, and to patient experience, describing some current feedback mechanisms.

Any Financial Implications from this Paper

None specified

Any Staffing Implications from this Paper

None specified

Any Equality Implications from this Paper

None specified

Any Health Inequalities Implications from this Paper

None specified

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.

None specified

Highlight the Corporate Plan priorities to which your paper relates

The high level aim
- improving quality, efficiency and effectiveness
- making further reductions in avoidable harm and in hospital acquired infection

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Date: 8th August 2016

Clinical Governance Annual Report 2015-2016

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Executive Summary

Each year the Board provides an annual report reflecting on its clinical governance arrangements and the progress it has made in improving the quality of clinical care. The report is structured around the three main domains set out in the National Quality Strategy: Safe, Effective, Person-Centred Care, and also contains a section on Nursing, Midwifery & Allied Health Professionals Directorate (NMAHP).

Under each of these headings there are examples of completed, continuing and newly commissioned programmes of work such as:

- NHSGGC Personal Outcomes Project examining how we can affect outcomes and delivery of care for patients through collaboration
- Morbidity & Mortality Meetings (M&M) improvement programme, providing guidance and coaching to optimise efficiency and learning from M&M meetings with the aim of improving patient safety.
- Clinical Quality Publication Tracking and the continual development of standardised processes providing NHSGGC with a framework to respond and action recommendations from applicable publications
- Successes with Scottish Patient Safety Programme, for example, 100% compliance with implementing the Adult Urethral Urinary Catheter (AUC) Insertion and Maintenance Care Plan across 87 wards to prevent Cather Associated Urinary Tracy Infection (CAUTI), and 7 wards who have shown great improvement in processes for reliably risk assessing patients on admission to hospital for venous thromboembolism and giving appropriate therapy to reduce the risks.
- Developing quality improvement capability, the report describes the success of the 1 day quality improvement workshop and the number of bespoke sessions commissioned as a result of its success.

The report will also highlight the role of Clinical Governance and a number of changes to the clinical governance arrangements in a period of substantial change and reorganisation within both the Acute Services Division structure and the integration and development of the Health and Social Care Partnerships.

The clinical governance annual report concludes with describing a range of areas which we require to progress over the coming year and they include:

1. Accelerating the implementation of key programmes to enhance patient safety and patient experience across the system.
2. Improving the dissemination and sharing the learning from serious clinical incidents across the organisation.
3. Developing effective teams with quality improvement capability throughout the clinical services to provide continuous improvement in clinical care.
4. Incorporating performance and outcome measures for improvement and accountability.
5. Making effective use of information technology to improve the availability of data for clinical outcomes and improvement.
6. Ensuring that clinical services have up to date evidence and guidelines in place to provide high quality care.
7. Ensuring that the new structures in place provide assurance to the board and ensure there is an awareness of the key clinical risks.
8. Learning and implementing any recommendations from external and internal quality reviews.
9. Review the various quality workstreams within NHSGGC to ensure that they work in the most effective way to enhance patient care.

1.   Introduction

1.1   NHS Greater Glasgow and Clyde (NHSGGC), one of 14 regional NHS Boards in Scotland, was formed in April 2006. It covers an area of 452 square miles in west central Scotland, providing services to a core population of 1.15 million. The organisation covers a diverse geographical area, including Glasgow, the largest city in Scotland, large and small towns, villages, and coastal and rural areas.

We employ 39,369 staff who deliver services across its core area, as well as regionally and nationally, providing specialist regional services to more than half of Scotland's population.

We are responsible for the provision and management of the whole range of health services

- 9 Acute Hospitals
- 52 Health Centres and Clinics
- 242 GP Surgeries
- 263 Dental Practices
- 184 Optician Practices
- 292 Pharmacies.

1.2   Each year the Board provides an annual report reflecting on its clinical governance arrangements and the progress it has made in improving the quality of clinical care. The report is structured around the three main domains set out in the National Quality Strategy: Safe, Effective, Person-Centred Care. This report will describe the main governance framework and demonstrate our work to improve the quality of care in our Board through a small selection of the activities and interventions. It is important to note that there is substantially more activity at personal, team, and service level arising from our collective commitment to provide a quality of care we can be proud of. This report can only reflect a small selection so is illustrative rather than comprehensive.

1.3   As we entered this year we were approaching a period of substantial change, which included a reorganisation of the Acute Services Division management structure, the establishment of Health and Social Care Partnerships and of course the reorganisation of clinical services with opening of new Queen Elizabeth University Hospital and the new Royal Hospital for Children. Throughout this period we have been working with services to ensure that clinical governance arrangements remain robust and reflected the revised arrangements.

2.   Clinical Governance Arrangements

2.1   During this reporting period (March 2015 to April 2016) the governance of clinical quality has been overseen by a combination of the NHSGGC Board and its standing sub-committees. During the year, as a result of the reorganisation within the NHS Greater Glasgow and Clyde, the Acute Services Committee (ASC) replaced the Quality and Performance Committee (Q&PC) from 1st July 2015. These sub-committees take an overview of clinical governance and, on behalf of the Board, seek assurance that clinical governance arrangements are working effectively to safeguard patients and improve the quality of clinical care.

2.2   The Non-Executive oversight of clinical governance arrangements through the Board and its sub-committees for Acute Services are supported by the Medical Director as Executive Lead for Clinical Governance and the Board Clinical Governance Forum.

2.3 The Board Clinical Governance Forum has coordinated a number of changes to the clinical governance arrangements, which includes;

1. Changes to the content and format of corporate clinical governance reports to more fully reflect the scope of clinical quality improvement activities.
2. Testing and standardising terms of reference and agendas for clinical governance forums to ensure greater consistency across different service settings.
3. Describing and reviewing the clinical governance arrangements to confirm structural connections are intact following the major organisational change.
4. Setting up a new process for regular, systematic review of clinical governance priorities and progress in each of the Acute Services Sectors and Directorates.
5. Initiating a new Clinical Quality Improvement Network (CQiN) to support staff develop skills and practice in the techniques of quality improvement.
6. Developing specifically tailored local objectives to support progress on key safety priorities.
7. Completing the consultation and redrafting of a new NHSGGC Clinical Governance Policy.

As Health and Social Care Partnerships were being established we observed great cooperation in health and social care staff to find new ways of learning from each other and many examples of effective leadership.

"As Chief Officer for Glasgow Health and Social Care Partnership, I have made the need for robust Clinical and Care Governance a core element in the development of the HSCP. Clearly this is not just about having effective Governance structures and arrangements but also about creating the expectations and the environment for staff that ensures that good clinical and care governance is central to the practice of all staff. The three governance domains of safe, effective and person centred care are fundamental to all aspects of Health and Social Care, and highly significant in the achievement of good outcomes for service users and patients. While we continue to further develop the integrated governance structures within Glasgow HSCP, taking full account of how they must inter-relate with those of the Health Board, I will continue to ensure that the emphasis is maintained on how these structures ensure quality services and good outcomes."

David Williams
Chief Officer Glasgow City HSCP

Best Care for Older People
In addition to the main structure of clinical governance arrangements, larger improvement aims often require dedicated structures.

An NHSGGC Best Care for Older People Group is now established and will be accountable to the Board Clinical Governance Forum. The group is chaired by the Board Nurse Director who is the Board Executive Lead for Older People. The purpose of the group is to provide oversight of the care of older people across NHSGGC. Acute Sectors/Directorates and Partnerships have nominated a member of their Senior Management Team to be the direct Older People's Lead/ Senior Nurse who will actively participate as a member of the group. This lead role within all areas will ensure that the Management Teams are fully engaged in the Older People's agenda and will ensure that multi-disciplinary teams are engaged in the ongoing improvement of services for older people in acute care. The group will meet on a six weekly basis and have clearly defined objectives. In May 2016, NHSGGC completed the Healthcare Improvement Scotland (HIS) Older people in Acute Hospitals self-evaluation which has been designed to facilitate NHS Boards to identify strengths and areas for improvement independent of external inspection activity. An improvement action plan has been developed for the Best Care for Older People Group based on the outcomes from the Healthcare Improvement Scotland (HIS) self-evaluation.

3 Person-Centred Health and Care Programme

3.1 NHSGGC publish an Annual Report on Feedback, Comments, Complaints and Concerns which provides a broader description of the use of patient feedback to improve the quality of care. This section showcases the work linked to the national Person-Centred Health and Care Programme (PCHC) and supported by Healthcare Improvement Scotland (HIS).

3.2 The main remit of the PCHC Programme team in NHSGGC is to gather "real-time" feedback from people using services at the point of care in a small cohort of clinical teams in both the Acute Services Division (ASD) and the Health and Social Care Partnerships (HSCP's). The feedback is used specifically to influence and drive improvements in person-centred care at a local level and to design improvement interventions and actions through a coaching, mentoring and support relationship with clinical teams. The main method of listening to the care experience of patients, relatives and carers is through a locally developed process which is described as a "themed conversation". The enquiry concentrates predominantly on gathering and developing feedback on experience of the person-centred principles of care giving. Both quantitative and qualitative feedback is gathered over consecutive monthly cycles and is reported directly back to the clinical teams and their managers. The continuous cycle of gathering feedback helps the clinical teams to evaluate the impact and outcome of the improvement interventions and actions they have implemented on the care experience of people they come into contact with.

3.3 The following are a few examples of improvements which have been developed in specific clinical teams over the last year.

Ward 62, Oral and Maxillofacial Surgery, Institute of Neurosciences, Queen Elizabeth University Hospital

Improvement Aim	Improvement Intervention	Outcome / Learning
To improve communication, information sharing and privacy during the daily ward round.	To use the treatment room as the main location for ward round consultation and optimise privacy. To start the conversation with 'what matters' to the patient in relation to their plan of care and progress achieved / next steps. For all multi-disciplinary team members to be present to enable consistency and continuity of information sharing.	The treatment room offers a level of privacy not previously achievable in shared rooms. Identifying 'what matters' enables an individualised approach to care and personal choices and preferences to be acknowledged. Repetition or contradiction of information is minimised. Discharge planning is more efficient.

Musklo-skeletal Physiotherapy Service, Royal Alexandra Hospital, Paisley

Improvement Aim	Improvement Intervention	Outcome / Learning
To check understanding of verbal and written information provided at clinic appointments on proposed exercise plan.	To use the 'Teach-back' technique to check that patients understand the verbal and written instructions given to them. 'Teach-back' is an evidence based health literacy intervention used to check that the health professional has clearly explained information to the patient and that the patient has understood what they have been told. Further information on the approach can be found on http://www.healthliteracyplace.org.uk/tools-and-techniques/techniques/teach-back/	Increase in patient confidence to undertake prescribed exercises and participation in their self management between clinic appointments. Corrections and modifications can be made to the information before the patient leaves the clinic. More efficient and effective use of physiotherapy treatment time.

Ward 2, Care of the Elderly, Rehabilitation, New Victoria Hospital

Improvement Aim	Improvement Intervention	Outcome / Learning
How to find out 'what matters' to people with communication support needs.	To use the Talking Mats© approach to facilitate improved communication with older adult patients who have communication support needs to find out 'what matters to them' and how this information can be used to plan their care and support needs. The Talking Mats© approach is a visual framework that uses unique picture symbols to help people with a communication difficulty to communicate more effectively and express their views about their health and well-being needs, their eating and drinking preferences, their personal care needs etc. Further information on the approach can be found on http://www.talkingmats.com/	Assisted staff to find out patients' views and personal preferences, which has not been disclosed or identified through other communication and assessment processes. Enabled the staff to involve patients in the planning of their care more effectively. Enabled nursing staff to provide a more person-centred and individualised approach to care provision in the ward.

3.4 NHSGGC Personal Outcomes Project

In Scotland the Personal Outcomes Approach has been developed as a way of making sure that what matters to someone and what they want to change in their lives lies at the heart of the support and care that they receive. It is an Asset Based Approach which recognises the contribution of the person themselves and their own resources to achieving their outcomes, consistent with the principles of co-production.

A yearlong project which commenced in March 2015, was co-designed and delivered in partnership with colleagues from the Personal Outcomes Partnership* and the ALLIANCE as part of the People Powered Health and Wellbeing Programme.

> *The Personal Outcomes Partnership (POP) formed between the Joint Improvement Team, Thistle Foundation and the ALLIANCE to bring together their experience providing Training and Consultancy in person-centred care, co-production, self management and talking points to support local teams and partnerships across health and care to embed a personal outcomes approach into practice.

From March 2015 to March 2016 seven clinical teams in NHSGGC participated in a development and improvement opportunity to explore and evaluate how the application of personal outcomes approaches could achieve improvements in person-centred health and care delivery by integrating personal outcomes and asset based approaches to assessment, care planning and delivery.

1. The Thistle Foundation supported a series of learning and development sessions.
2. The Person-centred Health and Care (PCHC) team provided coaching and mentoring support to assist practitioners to translate learning into practice using improvement thinking to test and use personal outcome approaches.
3. The People Powered Health and Wellbeing (PPHW) team facilitated the use of a variety of methods to capture learning from participants to inform an evaluation of the programme.

A structured but flexible approach was designed for participants to:

1. Gain an in depth understanding of personal outcomes and asset based approaches;
2. Support practitioners to test and develop use of the approach to facilitate 'good conversations' with people and record information gained from this to inform care planning and service delivery;
3. Evaluate how the approach could improve the care experiences of people who use their service to achieve 'what matters' either independently or with additional support.

An evaluation report commissioned by the Head of Clinical Governance has been compiled and written by Dr Lisa Curtice, Associate Director, the ALLIANCE and Dr Emma Miller, Senior Research Fellow, School of Social Work and Social Policy, University of Strathclyde. The findings and recommendations of the report will be used to inform a discussion of future planning of these approaches in care delivery and service models in NHS GGC. The following is a short excerpt from the evaluation findings and recommendations.

- With a strong focus on conversational skills in the staff development sessions, these appear to have provoked considerable thinking and promotion of practice change with positive reflective accounts from practitioners indicating their awareness of taking a step back, deeper listening and of abandoning the habit of developing a preconceived plan of what could be right for the person, before having the conversation and feeling enabled to listen more effectively to what was important to the person.
- Where practitioners adopted a recognised criteria and tool for recording personal outcomes and planning this was viewed to make a significant difference to facilitate

onward communication, review and evaluation, and identification of sources of support and other resources.

- There was wide spread recognition that changing the conversation could have beneficial effects on the quality of the relationships, linked to the content of the sessions, and later to experiences of practising these skills.
- Although the concept of personal outcomes is simple at face value, understanding of its complexity as well as a flexible and responsive approach, are essential to successful implementation.
- Greater clarity is required about the similarities and differences with other approaches which essentially focus on involving people in decision making and person-centred practice.
- Flexible and responsive facilitation is essential to accommodate variations in who teams are working with, their organisational structure and culture and level of existing relevant experience.
- The different roles played by practitioners influenced and sometimes restricted what part they could play in putting personal outcomes approach into practice, particularly where they had no influence or input to personal planning.
- Embedding the approach needs to be viewed as a long term game, requiring organisational ownership and commitment from senior management.

The full report will be published on the Clinical Governance Support Unit (CGSU) StaffNet pages in the next few months
http://www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/Clinical%20Governance/Pages/PersonCentredHealthandCareProgrammeReports.aspx

3.5   National Person-Centred Care Event: Putting people at the centre of health and care: celebrating success so far – Thursday 25th February 2016

Healthcare Improvement Scotland hosted a National Person-Centred Event on the 25th February 2016 at the Golden Jubilee Conference Hotel, Clydebank. The title of the event was 'Putting People at the Centre of Health and Care: Celebrating Success So Far'. The event was designed to provide an opportunity to reflect on the journey of the Collaborative since 2013 and to celebrate the developments made in each Health Board area around person-centred care and person-centred approaches.

The day provided the opportunity to share a variety of examples of improvement work which has been tested and implemented in NHSGGC, alongside other presentations from across Scotland. Six groups of staff from NHSGGC had the privilege of presenting their work in workshops and breakout sessions. These included:

- Shona Monaghan, Senior Charge Nurse in Ward 62 at the QEUH who explained how they developed a more person-centred approach to the daily ward round by testing and designing improvements based on the feedback received from patients.
- Helena Bancroft, Staff Nurse in Ward 19 at the RAH shared how the team used digital technology to share information in the surgical palliative care setting at the RAH to help alleviate fears and anxieties of patients being referred to the ward.
- North West Older People Mental Health Team shared their experience and learning of being involved in the co-design project 'Keeping it Personal' lead by IRISS (Institute for Research and Innovation in Social Services) which brought together people with lived experience and health and social care practitioners to work in equal partnership: learning together; improving together; and sharing the learning of the project.
- Sandra McGuire, Service Development Lead, Renfrewshire HSCP shared an approach modelled around the 'House of Care' as a framework for having person-centred care planning conversations and supporting self management for patients visiting their GP with Long Term Conditions.

In addition there were eight posters presented by clinical teams in NHSGGC to showcase their work and share their learning.

1. Exploring the application of personal outcomes approaches to achieve improvements in person-centred health and care delivery in Acute and Primary Care settings.
2. 'Keeping it Personal' co-production project lead by IRISS (Institute for Research and Innovation in Social Services) which brought together people with lived experience and health and social are practitioners to work in equal partnership: learning together; improving together; and sharing the learning of the project.
3. How Auchinlea Mental Health Resource Centre explored how 'community mapping' approaches can help to connect people with the local community they live, work and socialise in, and how this helps them to keep well.
4. Using the Teach-Back approach in Musculoskeletal Physiotherapy to check understanding of exercise instructions at their clinic appointment and how this has helped to promote improved self-management.
5. Using the Talking Mats© approach to facilitate improved communication with older adult patients who have communication support needs to find out 'what matters to them' and how this information is used to plan their care and support needs.
6. Encourage family and carer presence during mealtimes to assist with feeding and with social interaction that they are familiar with, while eating.
7. How the #Hellomynameis... campaign has helped to raise awareness of the importance of making verbal introductions to people using health and care services in NHS GGC.
8. How co-design of knowledge management approaches helped to support clinical teams involved in the Person Centred Health and Care Programme.

All posters and presentations are available on the PCHC Programme StaffNet pages. http://www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/Clinical%20Governance/Pages/PersonCentredHealthandCareNationalEvent-February2016.aspx

4. Patient Safety (& Clinical Risk Management)

4.1.1 Introduction

4.1.1   It is the experience of all healthcare systems across the world that patients will occasionally suffer harm whilst being cared for. NHSGGC seeks to minimise the frequency and degree of such instances of patient harm through an approach collectively described as clinical risk management. One aspect of clinical risk management is collecting and analysing information relating to the causes or potential causes of harm to patients, then by applying this learning, seek to improve levels of patient safety and well-being.

4.1.2   In reviewing the following section on safety it is important to understand that for the majority of patients their care is delivered without mishap or an adverse outcome. It is also helpful to understand the scale of activity associated with NHSGGC. Each year, for instance, our acute hospitals will have treated and discharged in excess of 350,000 patients in wards or in day care. In community services GP and practice staff will have seen over 1 million patients, community nurses provided around 1.5 million visits to patients in their own homes and over 20 million medicines were dispensed by Community Pharmacists.

4.1.2 Clinical Incident Reporting

4.2.1   Datix is a Board wide electronic web based incident reporting system which has the ability to collect information when a patient's care or treatment do not go to plan so any weaknesses in our clinical systems can be improved to reduce risk and improve quality.

We actively encourage our staff to report all patient safety incidents through this system as this provides us with an opportunity to learn from the issues raised by staff so that we can continue to improve the quality of patient care. In the last year substantial time and resources have been implemented to improve the incident reporting function of Datix. Improved governance arrangements with the establishment of the Datix Steering Group and the revitalised Datix User Group have been implemented. System upgrades and function enhancements have been put into practice to not only provide additional information but also making the system more user-friendly. There have also been improvements in the training provision with both online and face to face options available.

Example of Datix system improvements:

- Reduction in the number of fields for staff to complete to save time.
- Review of all category codes to ensure they are intuitive and relevant.
- Automatic feedback to the reporter of the incident of response to the report.
- Improved server function so the system runs quicker.
- Extra fields added for particular types of event such as falls to save attaching an extra form while providing robust information for analysis.

4.2.2   All of those events with the greatest learning potential are defined as Significant Clinical Incidents (SCIs) and are subject to a comprehensive investigative review to identify the potential for improvement to systems of care. The Clinical Risk Team has worked with services over this last year to ensure the policy is being followed and the actions from them are implemented. The services receive a list monthly of their open SCIs and any potential serious incidents that have not yet been declared SCIs. The use of the 'actions' module has been introduced this year which allows collection and reporting from Datix on all the actions generated from each event.

4.2.3   The Clinical Risk department also introduced the ability to monitor some aspects of Duty of Candour from the Datix system such as if patients / relatives have been informed of the adverse event and also if they have been involved in the investigation for the serious events. This information is then reported back to service.

4.2.4   Quarterly incident reports are produced for all the clinical services and aggregate reports of SCIs are produced for the Acute Division and Partnerships.

4.2.5   In analysing the events we have found an increased awareness in ensuring the patient has been informed or of the event and an apology given. We have also seen an increase in the number of patients / families met following an event to discuss the investigation outcome. Although we recognise this is very much an improvement in terms of patient/relative engagement we believe some training in how to broach these conversations would be helpful. A pilot of training is currently in the planning stage with implementation in autumn 2016.


Feedback from patients:
- When a patient was contacted following an event to explain a SCI investigation was going to take place and that we were interested in arranging a time to hear the patient's perspective he was very pleased that "his side of the story" was going to be considered and that he "got the opportunity to be involved". He also asked if a relative could be spoken to who had witnessed interactions and this was also accommodated.
- When a patient was met following the investigation to again apologise and to explain what had happened and the findings of the review he was very grateful to have the process that led to his error explained to him.

4.3   Significant Clinical Incidents

4.3.1   The following charts provide an outline of our experience of Significant Clinical Incidents reported since April 2008. An important point to recognise is that although reported, these are not indicators of poor clinical performance. The data in this section will also include near miss situations where no immediate harm was suffered, but could recur if conditions or causes are not remedied. A further proportion of reported events will be unavoidable arising from the complex presentation of seriously ill patients.

Chart : 1 Significant Clinical Incidents reported since April 2008 – March 2016.
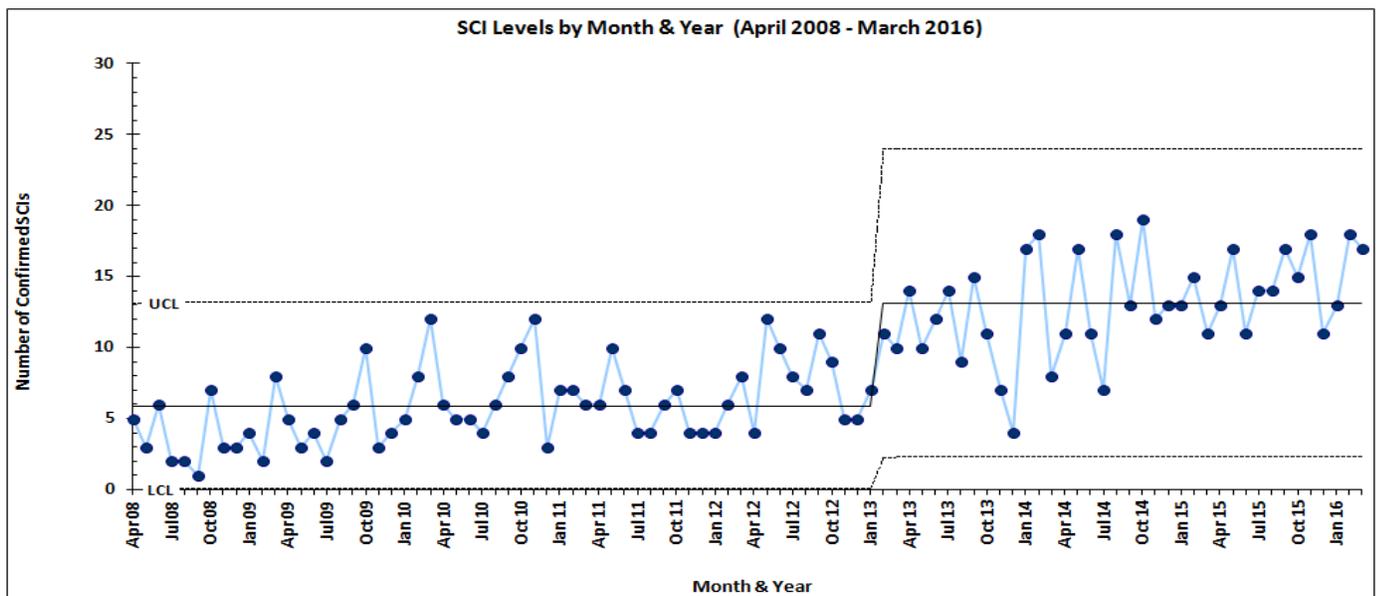

4.3.2   The chart above demonstrates an increase in the number of reported significant clinical incident reviews over an eight year period however the main reason for the increase is that the threshold for events that would be considered a significant event has lowered. Clinical teams have found a benefit in reporting events as SCIs and therefore have changed practice to ensure this level of investigation is performed in an increasing range of circumstances.

4.3.3   In the last year (April 15 – March 16) there was a total of 260 SCIs reported of which 180 were Acute and 80 Partnership (Chart 2). This is an increase of 20 events in Acute and a decrease of 8 events in Partnership from the previous year (248). There has been an average of 22 per month.

4.3.4   Although there has been a slight increase in events reported by Primary Care there has been a drop in reporting by Mental Health as the number of suicide events has reduced from 44 the previous year to 38 in this year.

4.3.5   In the Acute sector there has been a slight increase in SCI falls, an increase in blood transfusion events and an increase in infection control events. The most significant increase in the category of events reported is clinical other. These are predominantly patients who have suddenly deteriorated or unexpectedly died and an SCI investigation has been carried out to provide assurance that these were unavoidable events. This has increased this past year by 10 events which indicate a willingness to review patients with a poor outcome to establish if something could have been done differently. The majority of these events conclude that the outcome could not have been avoided.

Chart 2: Significant Clinical incidents reported April 15 – March 16

SCI events Apr 15 - Mar 16
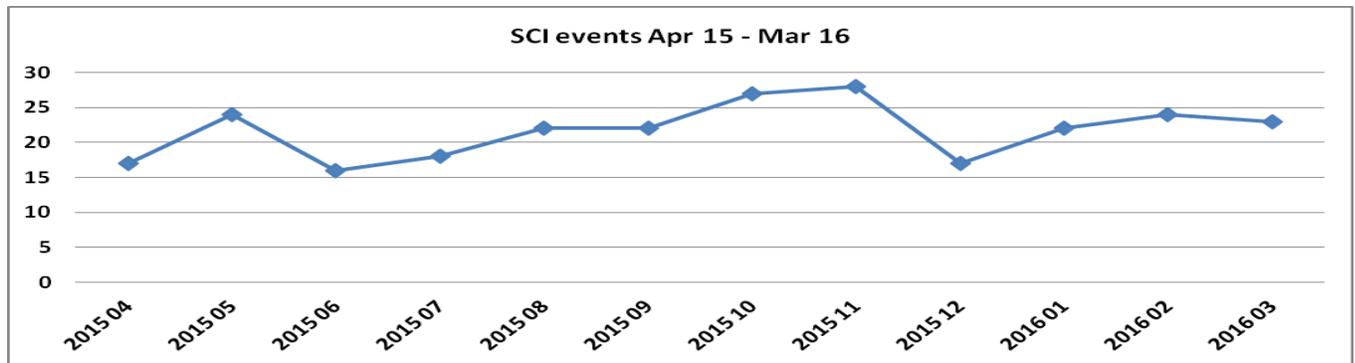
4.3.6 There is a decrease in the Acute Division of 'treatment issues' such as delay in diagnosis or delay in treatment. There is a decrease in theatre process problems such as retained items during surgery or problems related to surgical implants. There is a marked reduction from 27 events in the previous year to 14 events in this year relating to the inaccurate labelling of specimens. Inaccurate labelling can lead to patients receiving the wrong diagnosis from a biopsy or delay in receiving diagnosis until an investigation reveals the true identity of the specimen. Analysis of wrong labelling events in the previous year prompted the service to ensure Standard Operating Procedures were robust and procedures to improve compliance were implemented. The SCIs also highlighted traps that cause error producing conditions and awareness of these has also helped reduce incidents.

4.3.7 There have been more SCI investigations over the last year generated from complaints which would have previously continued as complaints. A new process established in 2015 allowed some complaints to be transferred to the SCI process due to the level of investigation required due to the complexity of the event to ensure learning and a satisfactory response to the complainant.

4.3.8 In addition to our routine reporting we have also noticed a number of Ombudsman reviews provoke an SCI which often also involve another Board. Although the NHSGGC component of the patient pathway may be small we work with the other Board to ensure a comprehensive and informative report is produced.

4.3.9 The two charts below (3&4) demonstrate the 5 most reported categories of SCI for Acute and Partnership areas.

**Chart 3 Top 5 SCI Categories in Acute**

Top 5 SCI catgories in Acute
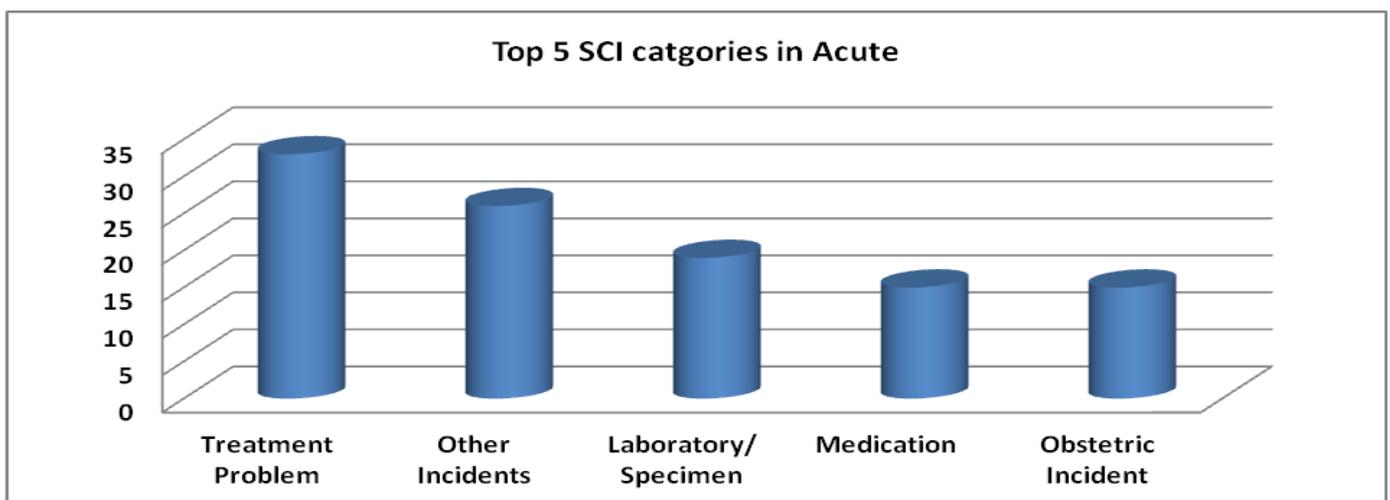
Examples of improvements to systems and processes following investigation made

- An Ambulatory Care Unit was opened in November 2015 to improve triage in the Immediate Assessment Unit in the QEUH.
- Examination mirrors have been purchased for dermatology clinics to allow patients to view and identify lesions and proposed surgical sites to ensure both patient and clinician are clear about the planned procedure.
- A Gentamicin patient information leaflet has been created and is available to all wards. This is important as this medication can have side effects which the patient should look out for such as hearing loss.
- The Standard Operating Procedure in Blood Transfusion has been changed to improve clarity of instruction following a blood transfusion incident.
- An Anaesthetic induction medication has been purchased in pre-filled syringes for obstetric theatres to reduce errors confusing this medicine with another medicine which is prepared in the same way and looks identical in the syringe.

4.3.10   Reducing harm associated with medicines

Medicines are the most common intervention provided in healthcare. Key stages in the system of medicines use are illustrated in figure 1. Each stage represents multiple processes and opportunities for human error and systems failure.

Figure 1: Medication Processes
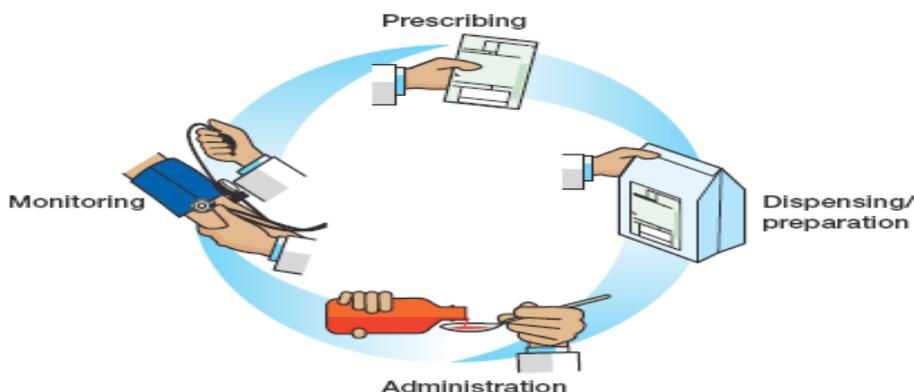
In NHSGGC there were 3,263 medication incidents reported in Datix in 2015/16. This represents 17% of all clinical incidents reported. The vast majority result in no/minor harm, but 28 incidents were categorised as significant and subsequently investigated to identify root causes, system defects and key learning points. Independent contractors do not report in Datix and have their own arrangements for reporting, investigating and learning from clinical incidents

Each Sector/Directorate is responsible for their own clinical governance arrangements, which will review learning from medication incidents and agree actions to reduce the risk of recurrence. Significant Medication Incidents are communicated across the Board using a standard learning report template. Pharmacy & Prescribing Support Unit (PPSU) facilitates sharing of the learning from incidents across services and with groups such as ADTC Safer Use of Medicines sub-group, Antimicrobial Utilisation Committee and Thrombosis Committee. Key themes and learning points are regularly communicated to service areas via NHSGGC Medicines Update bulletins and incorporated in education and training sessions for staff.

> **NHSGGC activities to reduce harm from medicines**
>
> - Scottish Patient Safety Programme: Medicines Reconciliation
> - Development and standardisation of prescription charts e.g. insulin
> - Safer medicines administration activities e.g. Missed dose audits, 'no interruptions' policy, 'Chance to Check' initiative
> - Improved antimicrobial stewardship
> - Safer use of high risk medicines e.g. gentamicin, anticoagulants, disease modifying anti-rheumatic drugs (DMARDs) and cytotoxic chemotherapy.
> - Clinical Pharmacy Triage and care prioritised according to patient risk

Chart 4 Top 5 SCI Categories in Partnerships
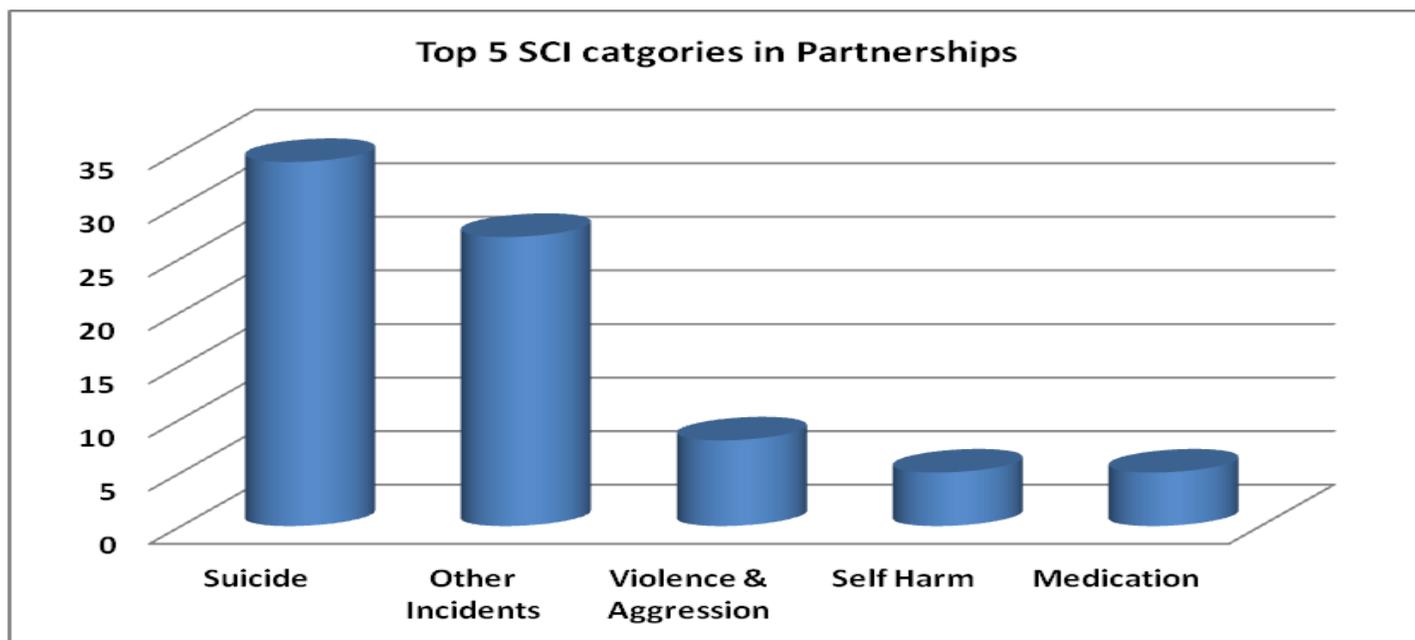
4.3.11   Within Partnerships the highest category has always been suicide within Mental Health Services. This category includes attempted as well as completed suicide. A reduction in these events has been noticed when comparing this year with the previous year which is also recognised in National Suicide review data.

In 2014/15 there were 44 suicide incidents reported with 40 of these being completed suicide and in 2015/16 there were 34 suicide incidents reported with 32 of these being completed suicide. Of the 20 investigations that have closed for suicide incidents this year 14 were thought to be unavoidable with 6 events concluding that the organisation may have contributed to the event but did not have total responsibility for it.

The other incidents in both Acute and Partnership are mostly unexpected death or sudden deterioration.

4.4   Avoiding Serious Event Monitoring

4.4.1   The Board has a list of events that are considered avoidable due to the systems and processes in place to prevent known risks. In NHSGGC these are called ASEM events however some organisations call them Sentinel or 'Never Events'. The table below demonstrates the ASEM events reported over the past year.

Type	No
Serious blood transfusion incident	4
Death or serious harm related to the use/function of a device	1
Surgery performed on wrong body part	4
Local anaesthetic performed on wrong body part	2
Wrong surgical implant	1
Retained item during surgery or procedure	4
Medication error	18
Venous thromboembolism	17
Naso Gastric Tube Misplacement	2
Total	53

4.4.2 The blood transfusion incidents were a combination of laboratory and ward based staff errors and all related to policy not being followed correctly. The medication incidents involved a variety of medicines with the most common type of drug involved being antibiotics. The wrong surgical site events were fortunately involving minor procedures and did not result in significant harm.

4.4.3 Two of the retained items were swabs and were due to failure to follow the swabs and instruments count policy, one was a surgical device due to the note of this accidently being removed from the board used by the scrub nurse in theatre and the last one was a retained guide wire following the insertion of a central venous line.

Raising awareness of events:

The Acute Patient Safety Bulletin contained articles on:
1. Raising awareness of surgical swab retention and how to display surgical swabs for counting to reduce error.
2. Raising awareness of guide wire retention and introduction of a pause before removing part of the device (sheath) to check the guide wire has been removed.

4.5 Sharing lessons learned

4.5.1 During this year we have promoted the use of 'learning summaries' to share information from SCIs. This is a one page easy to read document and is being piloted with medication errors at the moment. These summaries are also shared nationally on a National Health Improvement Scotland Community of Practice website which allows lessons to be shared across all Boards in NHS Scotland. The Community of Practice members are representatives from each board with a remit to collectively work on patient safety related issues.

4.5.2 Current negotiations are underway to use scenarios from clinical incidents for clinical simulator sessions so real life examples can be used as teaching sessions. There are two streams to this work as both acute adult and neonatal scenarios are being considered. The aim will be to produce a resource that can be used for multidisciplinary training. One of the cases being considered relates to a patient experiencing an air embolus following removal of a central venous catheter.

4.6 Training and Education for Patient Safety

4.6.1 Training for NHSGGC staff continues for SCI investigation, Root Cause Analysis and Human Factors. There is also Human Factors training as part of the Quality Improvement 1 day training programme.

Root cause analysis (RCA)

- Is a method of problem solving used for identifying the root causes of faults or problems. A factor is considered a root cause if removal thereof from the problem-fault-sequence prevents the final undesirable event from recurring.
- A root cause analysis investigation aims to examine the processes of care to identify if any system failures occurred which contributed to the incident and the patient outcome. This understanding is vital if the learning from these incidents is to be realised.
- Where system failures are identified, causal analysis should be undertaken to further understand why and how these can be managed to prevent recurrence. An investigation should consider how significant this failure has been in the overall incident (i.e. if multiple failures how they relate to each other) and also how they impacted on the patient and subsequent outcome.

Human factors (HF)

- Encompass all those factors that can influence people and their behaviour. In a work context, human factors are the environmental, organisational and job factors, and individual characteristics which influence behaviour at work.
- Part of the reason for undertaking an SCI Investigation is to establish if appropriate care was given and if not, why not. We cannot do this without considering the people within the system, which is considering the human factors. We know that people can make mistakes; we have to understand why mistakes are made to be able to respond to them properly; asking people to try harder or remember more is not the answer.
- Human factors have been applied by different industries for years and the benefits in healthcare are now being recognised. In an investigation we can consider if any of these factors were present and contributed to the event which occurred. If so then responses need to be considered to mitigate these factors in future circumstances.

4.6.2 The SCI toolkit has been updated and continues to provide a good resource for staff involved in investigating clinical incidents.

4.7 Morbidity & Mortality (M&M) Meetings

An effective Morbidity & Mortality meeting brings clinicians together to discuss unexpected patient deaths or patients who have had an adverse patient outcome. Selected cases are presented at these review meetings for the purpose of:

- discussing management decisions of cases
- providing a learning opportunity focussed on system thinking
- identifying opportunities to improve patient safety and quality of care

Morbidity & Mortality (M&M) Improvement Project:

An improvement project has commenced to improve the effectiveness of M&M meetings with the ultimate aim of improving patient safety and experience. This work involves production of some guidance tools that any team can use to assess their current effectiveness as well as some intensive coaching with pilot teams to help address the issues that they currently have. Part of the pilot is to offer an electronic web-based platform to record and manage M&M cases facilitating the ability to produce action plans and trend types of event. All 4 pilot teams are engaged and are at different stages of progress. The aim is for the pilot teams to be improved by December 2016.

5   Support to the Scottish Patient Safety Programmes (SPSP)

5.1   Introduction

5.1.1   Across the NHS Board services there are a number of areas where we are working with the Scottish Patient Safety Programme work streams, including Venous Thromboembolism Prevention (VTE), SEPSIS, Deteriorating Patient, Paediatrics, Neonatal, Mental Health and Primary Care. This section provides some headlines from this work.

5.2   Acute Adult Safety Programme

5.2.1   The aim of the Acute Adult Safety programme is to reduce harm and mortality to patients through the application of Quality Improvement methodology. The Acute Adult programme tests and implements processes that will further improve reliable care delivery across a range of clinical areas.

5.2.2   SPSP Deteriorating Patient Workstream

> *"The deteriorating patient work in NHS Greater Glasgow and Clyde has seen evidence based practice target the most vulnerable patients in acute hospitals, all members of the team work together to achieve high quality person centred care. With reliable spread the cardiac arrest rate has fallen to half the national average and a reduction in critical care transfers, in one hospital (the RAH) with spread continuing across all sites we hope to have similar results."*
>
> Dr Iain Keith,
> Quality Improvement Lead, Deteriorating Patient Programme

Aim:

- The overall aim of the work stream is to reduce the number of cardiac arrests in hospitals, by improving how frequently we observe patients and how we respond to patients who deteriorate.

Progress:

- 82 wards are working on Frequency of Observation in NHSGGC.

> **Frequency of Observations:**
> Monitoring a patient's vital signs is an essential part of caring for all patients, and should be recorded at the time of admission or initial assessment In NHSGGC. This is recorded using a National Early Warning Score Chart (NEWS), and NEWS should be used to monitor all adult patients in acute hospital settings. The frequency of monitoring should increase if abnormal results are detected.

- 28 wards are working on structured response in NHSGGC.

> **Structured Response:**
> Structured response is the way doctors and nurses respond and plan care for patients who are at greatest risk of becoming unwell.
> The things that should be documented are;
> - Documentation of active problems, working diagnosis, management plan and review time:
> - Frequency of Observations reviewed and documented:
> - Do Not Attempt Cardio pulmonary resuscitation (DNACPR) considered and completed if appropriate

* Continue to engage wards to increase the number of wards workings on deteriorating patient.

5.2.3   SPSP Sepsis

Aim:
* To ensure that all emergency unscheduled care wards in NHSGGC know how to treat patients with sepsis. In patients with sepsis, the aim is to complete the "Sepsis 6" bundle within 1 hour;
    * Oxygen therapy
    * Intravenous fluids
    * Blood cultures
    * Intravenous antibiotic
    * Measure lactate
    * Assess urine output.

Progress:
* A number of teams have already achieved the aim with others continuing to test and measure to achieve this.
*

> *"The sepsis work has been re-energised within Emergency Departments at Glasgow Royal Infirmary and Queen Elizabeth University Hospital led by two very enthusiastic consultants. Early days have seen two tests of change on the data collection methods and they are now at a point of collection. Both teams have support from all of the clinical staff in their local areas The Clyde Hospitals are getting better with the Royal Alexandra Hospital and Vale Of Leven Hospital now showing that they can have reached their goal and stayed there."*
> Julie McQueen ,
> Programme Manager, Sepsis

Next Steps
* Ensure the emergency departments and admission/assessment wards meet the aim by 31st December 2016.

5.2.4   SPSP Venous Thromboembolism Prevention

Aim
* To improve delivery of risk assessment and appropriate treatment to reduce harm and mortality from venous thromboembolism (VTE).

> **What are blood clots?**
> * A blood clot or 'deep vein thrombosis' (DVT) usually forms in the deep veins within the legs, but it can happen elsewhere in the body too. If the clot moves, or a piece breaks off and travels to the lung, it is called a 'pulmonary embolism' (PE). A PE is a serious condition that may result in serious illness, long term disability or even death.
> * Anyone can be at risk of developing a blood clot. However, some people are at higher risk than others. For example, if you are overweight, pregnant, taking a combined oral contraceptive, having an operation, are elderly or have cancer; and reduced mobility you may be at greater risk.
> * The VTE workstream aims to ensure that all adult patients admitted to hospital are risk assessed within the first 24 hours of admission and where appropriate to do so, are given an intervention to prevent a clot from developing.

Progress
- 27 wards confirmed into the programme across acute adult hospitals.
- There is an increased confidence in the changes tried and tested in the 7 wards which have demonstrated sustained reliability, which is defined as 9 or more data points currently with a median of ≥95%.

> **SPSP Venous Thromboembolism Prevention:**
>
> *"7 wards in NHSGGC who have shown great improvement with this particular workstream, and have met the aims set. The clinicians and improvement support staff have cited the following as important factors to help drive success with this work*
> - *Active and engaged clinical leadership*
> - *Start in areas which are direct admission areas and get it working there first*
> - *Standardisation of processes including risk assessment tool (generic VTE prevention risk assessment & guideline for majority of specialties*
> - *Embed the risk assessment tool within admission documentation*
> - *Checks and reminder systems with regards to ward rounds and handovers*
> - *Drug kardex with preprinted VTE reminder prompts*
> - *Patient Information Leaflet on VTE Prevention*
> - *Data collection made easy and useful (as minimal as it can be)*
> - *Active use of data*
> - *Well managed accountability and reporting structures*
> - *A what works register to share and support learning*
> - *Dedicated improvement support (Clinical Governance Support Unit improvement coaching to all active front line teams)*
> - *VTE Prevention resource pack*
> - *Targeted Quality improvement capability and capacity building"*
>
> Geraldine Jordan
> Head of Clinical Effectiveness, Programme Manager for VTE Prevention Workstream

Next Steps
- An overall plan for spread needs to be agreed and discussed with Executive Lead and Sectors/Directorates Senior Leads. The aim proposed for this workstream is spread to 50% of applicable wards by December 2016. This would be an increase of 38 wards from April 16 – December 16 if agreed. The proposed spread plan will be discussed at the August 2016 meeting of the Acute Services Clinical Governance Forum.

5.2.5 Medicines Reconciliation

Aim
- The process that the healthcare team undertakes to ensure that the list of medications a patient is taking matches the list held by GPs, hospital teams and community pharmacy.

> Medicines Reconciliation (MR) workstream is focussed on reducing patient harm from medicines. This is achieved by focussing on two areas in particular:
> - Patients with Medicines Reconciliation documented in the patient record within 24hrs of admission
> - Patients with a complete and accurate in-patient prescription chart within 24hrs of admission

Progress
- The primary focus to date has been improving medicines reconciliation (MR) on admission to Hospital. 45% of wards, which admit in-patients, are engaged in this workstream, including all receiving units. Current measures show between 50-60% of patients have MR documented within 24hrs of admission and 80-85% of patients have an accurate prescription chart within

24hrs of admission. In preparation for focusing on MR at discharge, GP practices across NHSGGC collected data on Immediate Discharge Letters (IDLs) they received, and reported that 80-90% of IDLs, from across all acute hospitals, have a satisfactory level of information about medicines and changes made during the patient's stay. The Acute Services Division has agreed the following three objectives for 2016/17:

Next Steps
- Ensure all clinical teams currently engaged in the workstream demonstrate a reliable medicines reconciliation process and accurate prescription chart within 24hrs of admission (by 31 March 2017)
- Ensure there is a spread plan that means all target clinical teams are actively engaged in the workstream to improve medicines reconciliation within 24hrs of admission (by 31 December 2016)
- Ensure there is a plan that means 50% of clinical teams are actively engaged in improving medicines reconciliation at discharge (by 31 December 2016)

5.2.6 Catheter Associated Urinary Tract Infection (CAUTI)

Aim
- The aim of the CAUTI workstream is to implement the NHSGGC Adult Urethral Urinary Catheter (AUC) Insertion and Maintenance Care Plan in acute adult wards and departments across NHSGGC by April 2016.

A urinary tract infection (UTI) is an infection in the urinary system, which includes the bladder and the kidneys. If you have a urinary catheter, bacteria or yeast can travel along the catheter and cause an infection in your bladder or kidney. The CAUTI Workstream is designed to deliver optimum care to patients who require urinary catheterisation and ensure that urinary catheters are inserted, changed and maintained appropriately.

The process and outcome measures associated with this work stream are:

CAUTIP1: Percent compliance with UUC (urethral urinary catheter) Insertion Bundle
CAUTIP2: Percent compliance with UUC (urethral urinary catheter) Maintenance Bundle
CAUTIO2: CAUTI Rate – per 1000 urethral urinary catheter days

Progress

- Roll-out of NHSGGC Adult Urethral Urinary Cather insertion and maintenance care plan
- 87 wards in total are engaged in the CAUTI work stream.
- 100% compliance with the CAUTI insertion and maintenance bundle

5.3   SPSP Paediatric

Aim
- The overall aim of the programme is to achieve a 30% reduction in avoidable harm in paediatric services by December 2015.

'In the past year we have continued to build on our safety and improvement work across paediatrics and neonates. Introducing the declaration of safety to our twice a day Huddles, means we now know which areas are most vulnerable and can take immediate action to ensure those areas get the appropriate support to ensure safety for both the patients and the staff.

We are working on our deteriorating patient bundle which includes sepsis and data collection around rapid unplanned admissions to Paediatric Intensive Care Unit.

A focus this year has been to build capability for improvement and we have had several nurses complete the Scottish Skills improvement course. In September all the senior charge nurses will attend the NHS Greater Glasgow and Clyde Quality Improvement day and will thereafter be supported through a Quality Improvement project by the clinical effectiveness team. We have also started a new Quality Improvement group for neonates which umbrellas the Scottish Patient Safety Programme Neonatal workstreams as well as other Quality Improvement projects across the three neonatal units. The group is so successful we are now planning to mirror it for paediatrics. Staff are energised by the work particularly with outcome data on Ventilator Associated Pneumonia and Pressure Ulcers demonstrating significant improvement. The next year we will continue to build capacity, work on deteriorating patient, medication, child protection and peripheral venous catheter and central venous catheter work'

Jen Rodgers
Chief Nurse for Paediatrics and Neonatology

5.4   SPSP Neonates

The measures for the neonatal workstream and individual unit participation are highlighted in the following table

Measure	PRMH	RHC	RAH
Compliance with CVC Insertion Bundle	√	√	
Compliance with CVC Maintenance Bundle	√	√	√
Compliance with PVC Maintenance Bundle			√
Compliance with Gentamicin Bundle	√	√	√
Gentamicin correct dose and frequency	√	√	√
Planned Extubations using Extubation Pause	√		
Newborn infants with new born screening		√	√
Compliance with Daily Safety Brief Bundle	√	√	√
Documented consultation with parents by an experienced clinician of the neonatal team within 24 hours of admission	√	√	√
Exchanges using High Quality SBAR			√
Compliance with Pre transfusion checklist - One Spot		√	

Progress

- Princess Royal Maternity (PRM) are measuring in seven areas. They are stepped down for one measure, demonstrating they have achieved the aim for two measures and are capable of achieving the aim with four measures.
- Royal Alexandra Hospital (RAH) are also measuring seven areas. They are stepped down in six measures and demonstrating sustained reliability in one measure. They are also engaged with an additional measure but are not yet submitting data.
- Royal Hospital for Children (RHC) are measuring in eight areas. Sustained reliability is demonstrated in three measures, reliability is demonstrated in a further three measures, one measure is deemed capable and is currently collecting and measuring data for one measure.

Next Steps
- New priority areas have been announced by the national team regarding deteriorating patients, neonatal hypothermia and late onset infection. Units will be supported in the implementation of these measures as soon as the details are available Units will carry on working towards completion for the outstanding measures.

5.5   SPSP Primary Care Programme

5.5.1   Introduction

The aim of the Scottish Patient Safety Programme in Primary Care is to reduce the number of events which could cause avoidable harm from healthcare delivered in any primary care setting. Within 2015-2016 there have been a range of work-streams which contribute to improving safety within the setting. The work is supported by clinicians and staff from the Clinical Effectiveness Team.

> *"GPs were asked to do medicine Reconciliation on patients discharged from hospital.   Feedback from one practice was that "there was Significant increase in patient safety by increasing the quality of their prescriptions by reducing prescribing errors by doctors undertaking med rec.*
> *They added that this has been one of the most valuable enhanced services that they have ever been involved in."*
>
> Dr Paul Ryan,
> Clinical Director, North East Sector

> Implementing systems for medicines reconciliation and the reliable prescribing of high risk drugs is key to improving patient safety. By implementing each measure of the appropriate care bundle and collecting data, you will see an increase in the reliability of care delivered to patients. Using the guidance, tools and resources available on this website will enable you to improve these systems within your own practice.

5.5.2 Medicines Reconciliation (PC)

Medicines Reconciliation is the process that the healthcare team undertakes to ensure that the list of medications a patient is taking matches the list held by GPs, hospital teams and community pharmacy

Progress
- The medicines reconciliation care bundle forms part of the "safer medicines" workstream and was included as part of the Locally Enhanced Service (LES). The current report at 30/3/16 shows 93% compliance with primary care immediate discharge letter care bundle. Since June 2014 this compliance has remained stable and is achieving 92-94% compliance.
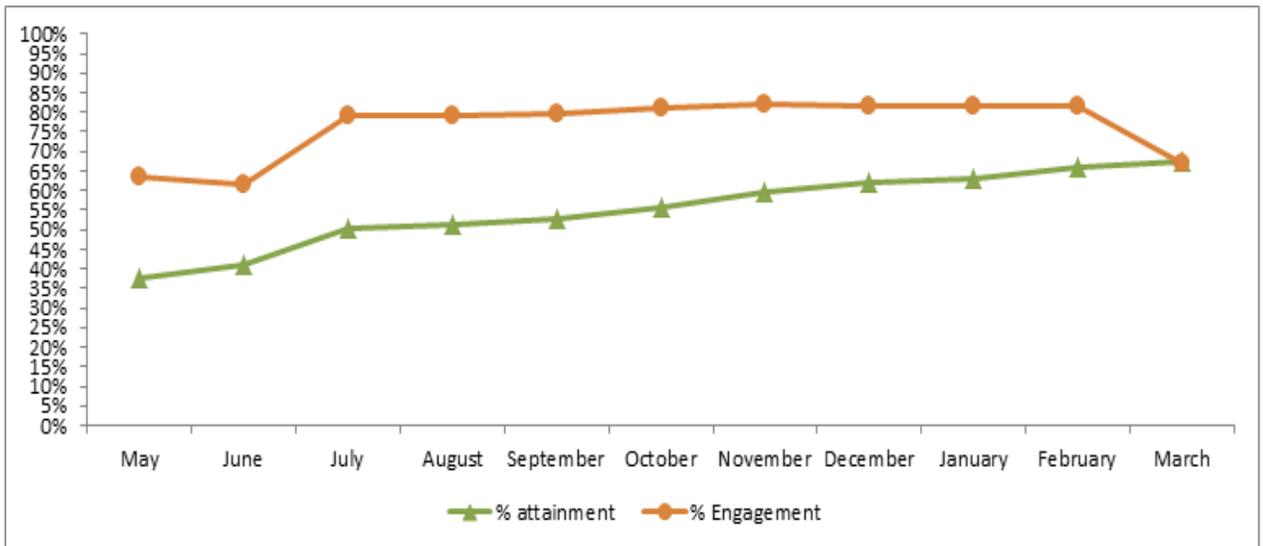
Next Steps

- There has been sustained compliance for a considerable time with positive impact on patient safety. Due to the changes in contracts no further funding is available to continue in its current LES format. While there is no fixed agreement on the next steps there may be scope for the prescribing support teams to continue to measure in practices selected for the investment fund with further potential to for GP clusters to adopt as their as their "Quality Improvement" area. There are also plans to develop work in Care Homes relating to CAUTI in the coming months.

5.5.3   Disease-modifying anti-rheumatic drugs (DMARDs)

> Disease-modifying anti-rheumatic drugs (DMARDs) are dangerous drugs which need to be carefully prescribed and monitored to keep patients safe and ensure they are properly treated.

Progress
- Through a care bundle approach 202 GP Practices across NHSGGC have been asked to report their prescribing and monitoring activity of disease-modifying anti-rheumatic drugs to reduce potential harm to patients. There has been steady progress with compliance with a recent test of change focussing on North East Sector due to lower rates of uptake. Over the period December-March, North East Sector has begun to show highest engagement rates of 70% compared to the Board average. The drop in engagement in March may reflect the perceived uncertainty with the continuation of Disease-modifying anti-rheumatic drugs due to the changes in GP contacts. The graph below highlights engagement and attainment rates from May 2015 to March 2016.
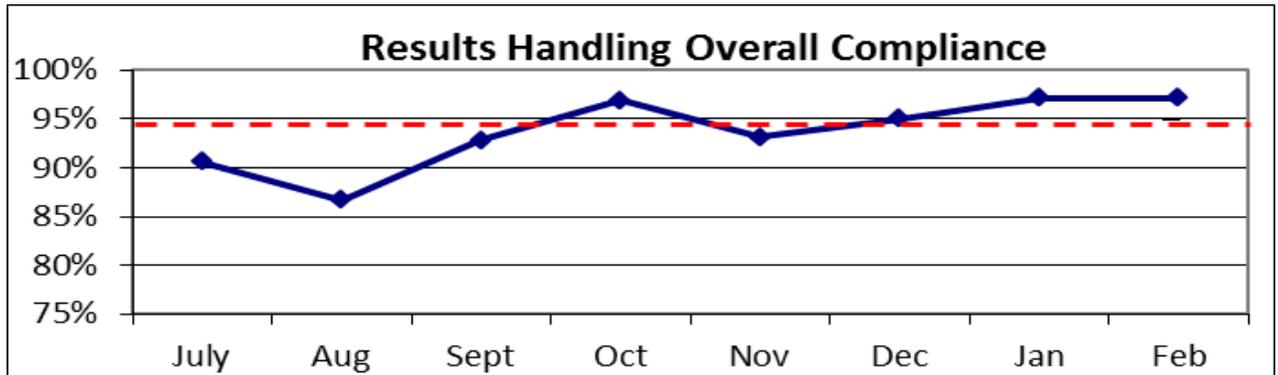

Next Steps
- The Disease-modifying anti-rheumatic drugs work will continue for 16/17. There is a plan to add additional Practice Nurse Support with the continued support from the Clinical Governance Support Unit. A Toolkit will also be developed to share the learning from Disease-modifying anti-rheumatic drugs and act as a practical guide to continue the work going forward.

5.5.4   Results Handling (PC)

Progress
- In a review of Significant Event Analyses (SEA) in general practice in Scotland (2009) 20% of SEAs related to results handling systems. In November 2013 a new results handing bundle was developed by NHSGGC and NHS Grampian. This has now been adopted nationally by

Healthcare Improvement Scotland (HIS) and rolled out to all other boards. In NHSGGC during 2015/16, 9 GP Practices have been involved in the Results Handling work. There has been significant improvement in compliance since the original Nov 2013 bundle, when compliance averaged at 60% across the participating practices. The chart below highlights compliance form July 2015 to Feb 2016.

Next Steps

*   The introduction of 'Ordercomms' has assisted with the significant improvement with compliance. This electronic IT system enables patient information and test results to be shared more smoothly and quickly between GP Practices and Hospital Services as they both have access to the one system. There is confidence that this will be in place for all GP practices in NHS Greater Glasgow and Clyde. Given the positive results and the reliable IT system it has been agreed that the results handing workstream will not continue in 2016/17.

5.5.5 Catheter Associated Urinary Tract Infection and Malnutrition Universal Screening Tool (PC)

Progress

*   Both the malnutrition universal screening tool (MUST) and catheter associated urinary tract infections (CAUTI) bundles have been developed and tested with positive findings. For malnutrition universal screening tool reports on compliance with bundle and nutritional status of patients who have had nutritional screening are carried out now and available via a dashboard on IT Community Nursing Information System.

Next Steps

*   There is a plan to develop the IT system so District Nurses can record catheter associated urinary tract infections electronically. This will allow greater understanding of impact and need and also assist with the overall spread and implementation of the catheter associated urinary tract infections tools for improved patient care.

5.5.6 Sepsis (PC)

Progress

*   Piloting the use of NEWS (National Early Warning Score) with 6 individual Out of Hours GPs we aim to be able to detect sepsis in adults at an earlier stage and more quickly arrange for hospital admission. Use of the NEWS tool has already shown that it helps GPs to record five physiological parameters consistently and reliably (Pulse, Blood Pressure, Respiratory Rate, Oxygen Saturations, Temperature) and assists with identification and diagnosis of Sepsis.

Next Steps

*   The GP's are planning to develop patient case stories to use within learning sessions, to provide a patient focused dimension to the programme. Plans to have future learning sessions and involve more GP's this year is underway. The feasibility of adapting the Out of Hours IT

System (known as Adastra) to improve the recording of Sepsis and the NEWS observations is being discussed.

5.5.7 High Risk Medicines (PC)

Progress
- The High Risk Medicines programme aims to reduce co-prescribing of high risk drug combinations (NSAIDs + other medications) by 90% by 30th June 2016 within the 9 participating Community Pharmacies. These Community Pharmacies are undertaking the pilot work with monthly data collection. Prescribing data is indicating a general decline in prescribing of NSAIDs in high risk patient groups and now seeing co-prescribing of NSAIDS and gastro protection by GP's.

Next Steps
- The pilot has now received extended funding until September 2016. There are discussions nationally and locally on consideration for local spread. In Jan 2016 we recently embarked on another project which aims for 95% of Patient(s)/Carer(s)s to have their medicines accurately reconciled in Community Pharmacy by July 2016. Key successes already has been formally involving the pharmacy teams in the discharge process which is having an advantage for reducing medicine waste as well as clinical advantages. Work is also underway to test the use of Medicines Sick Day rules cards.

5.5.8 Safety Climate Survey

Organisations working to develop or improve a culture of safety need a reliable measure to monitor the success of their initiatives. Using a safety climate survey tool, an organisation can gain information about the perceptions of front-line clinical staff about safety in their clinical area and management's commitment to safety. The survey also provides information about how perceptions vary across different departments and disciplines.

- The online safety climate survey collated through SafeQuest reports individualised and anonymised reports of the Safety Culture to each GP Practice involved. 90% of practices completed the survey. Each practice is expected to use the information to identify areas of risk and areas of good practice. An end of year report will be provided by HIS early June. This will be reported to the SPSP PC Group and the Partnership CG Forum.

5.5.9 Future

- The work undertaken within the Primary Care setting has been extensive and innovative. The SPSP PC Steering group have recently secured funding to develop SPSP work for 2016/17. Working alongside HIS and Local Partners work-streams will be agreed for the coming year in line with national and local priorities. East Dunbartonshire HSCP secured a recent improvement bid for 'Reducing Pressure Ulcers in Care Homes'. This work will add to the other activity within SPSP Primary Care.

5.6 SPSP Mental Health Programme

<u>Aim</u>
- Mental Health aims to systematically reduce harm experienced by people receiving care from mental health services in Scotland, by supporting frontline staff to test, gather real-time data and reliably implement interventions, before spreading across their NHS board area.

The ultimate aim of this programme is to ensure that our patients do not experience harm during their stay on our wards

<u>Progress</u>
- Leadership and Culture: All 14 wards have had Safety Conversations (SC) carried out in 2015. The actions are discussed at the Scottish Patient Safety Programme for Mental Health Steering Group on a regular basis. 30 actions have been identified from the 2015 SCs, of which 29 have been completed to date. All wards are participating in the staff and patient safety climate surveys.

The leadership and culture workstream involves asking the patients and the staff for their feedback about safety on our wards through questionnaires. The patient questionnaire is supported by Glasgow Mental Health Network. Senior leaders also visit a ward monthly where the results of the questionnaires are discussed. These visits are called safety conversations. Staff and patients are encouraged to raise safety concerns at these visits and a log of actions is kept centrally to make sure the organisation resolve these concerns.

- Risk Assessment: The risk assessment bundle has been updated in line with feedback from the 14 wards that were testing. The bundle has now been agreed and compliance has increased from 43% to 65%.

Every patient admitted to our wards should have an up to date risk assessment within 2 hours of admission. This risk assessment should then be accompanied by a management plan to ensure appropriate care. These should be developed in partnerships with our patients and carers where appropriate.

- Communication at Transition: A new bundle has been developed to check if patients are followed up within 7 days of discharge from hospital. Early results suggest that the definitions need more work. A video has been filmed for the wards to see an example of a Safety Huddle.

A pilot project is taking place giving ward staff access to electronic records to ensure that patients discharged from hospital are seen within 7 days of discharge. It is hoped that this work will reduce incidents and reduce the number of readmissions to hospital.

- Restraint: A bundle has now been developed for Restraint but will be tested in four of the fourteen wards. The bundle will ensure that a person centred care plan is in place and that should restraint occur that a debrief takes place.

> Within NHS GGC clinical staff are trained in the use of safe and effective restraint techniques. There are some clinical situations where short tem restraint may be necessary such as patients posing a risk to self or others. Staff are very aware of the distress that can be experienced by patients and others when restraint is required. The violence reduction team are now working with the staff on the SPSP wards to minimise the use of restraint and to ensure a debrief takes place should restraint occur. This debrief gives staff and patients the opportunity to discuss what, if anything could be better.   It is hoped that debrief prevents recurrence of these incidents.

- Safer Medicines: Safer Medicines included a sticker for wards to use in patients notes to highlight the use of 'as required' medication. All 14 wards are using these stickers and find them helpful. A bundle has now been developed to ensure that the 'as required' stickers are discussed at the multi disciplinary team meeting and changes to medications considered where necessary.

> On occasion our patients receive as required medication. The ward staff record the time, date and name of medication on a sticker to highlight the use of this medication. The safety programme in NHSGGC asks the staff to discuss this medication at the multi disciplinary team meeting and agree with the patient a management plan.

Next Steps
- The workstreams above will be rolled out to all Adult Acute wards before the end of 2016.

6 Clinical Effectiveness

6.1 Introduction

This report provides a summary of activity in 2015-2016, in relation to the following:

- Clinical Guidelines
- Clinical Governance Related Guidance & Clinical Quality Publications
- Quality improvement capacity and capability
- Quality improvement projects

6.2 Clinical Guideline Framework and Directory

6.2.1 Clinical Guideline Framework and Directory

The Institute of Medicine defines clinical guidelines, as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." NHSGGC recognised the need to improve the process for clinical guideline development, approval and review, and commissioned the development of a Clinical Guideline Framework and Directory to enable their storage and retrieval in 2012. The framework and directory underwent a period of consultation and review during 2015. Feedback was collated, themed and taken into consideration. The updated framework and directory were launched on Thursday 11th February 2016.

There were a number of changes to the framework; the most notable change is the steps taken to ensure a guideline is approved at the most appropriate clinical governance committee/forum. It is anticipated that this change will result in clinical guidelines being tabled at appropriate approving groups with completed checklists, and improve the effectiveness and efficiency of the current system.

Other changes to the framework include the introduction of a robust archiving process to ensure that each version of a clinical guideline which has been uploaded onto the directory is retained and can be easily retrieved, if required.
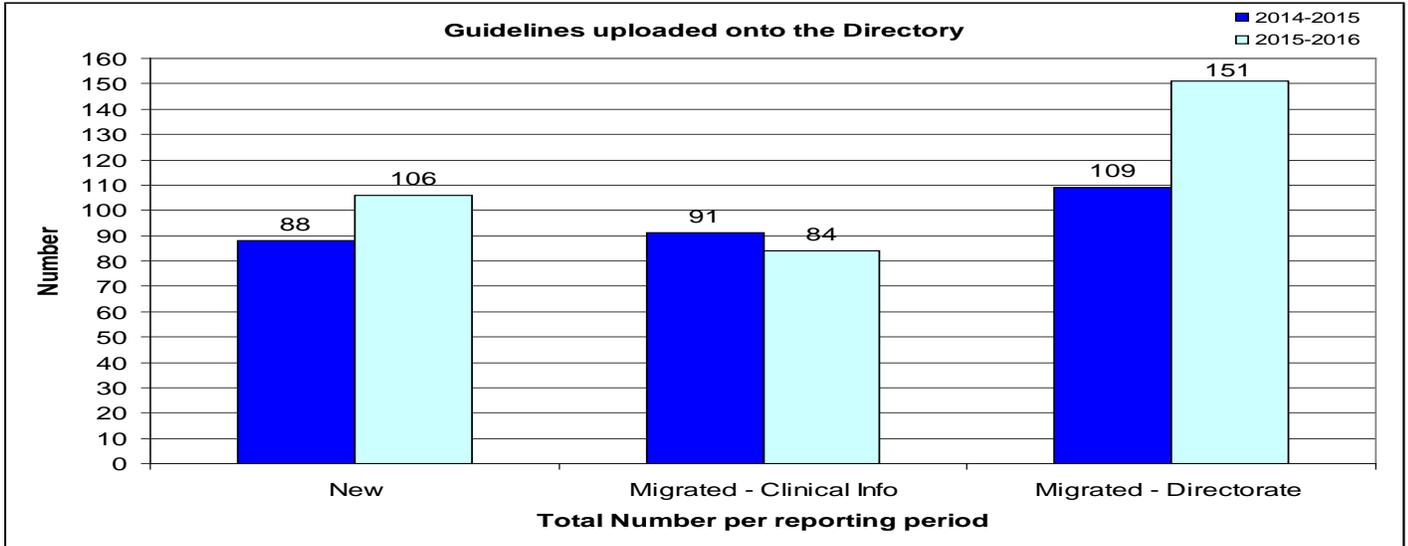
6.2.2 Clinical Guideline Directory

The consultation also highlighted challenges with the directory and its usability. The Clinical Effectiveness Team took this as an opportunity to liaise with Information Management & Technology (IM&T) to re-design the pages within the directory to be easier for staff to navigate and use, which we have received positive feedback on.
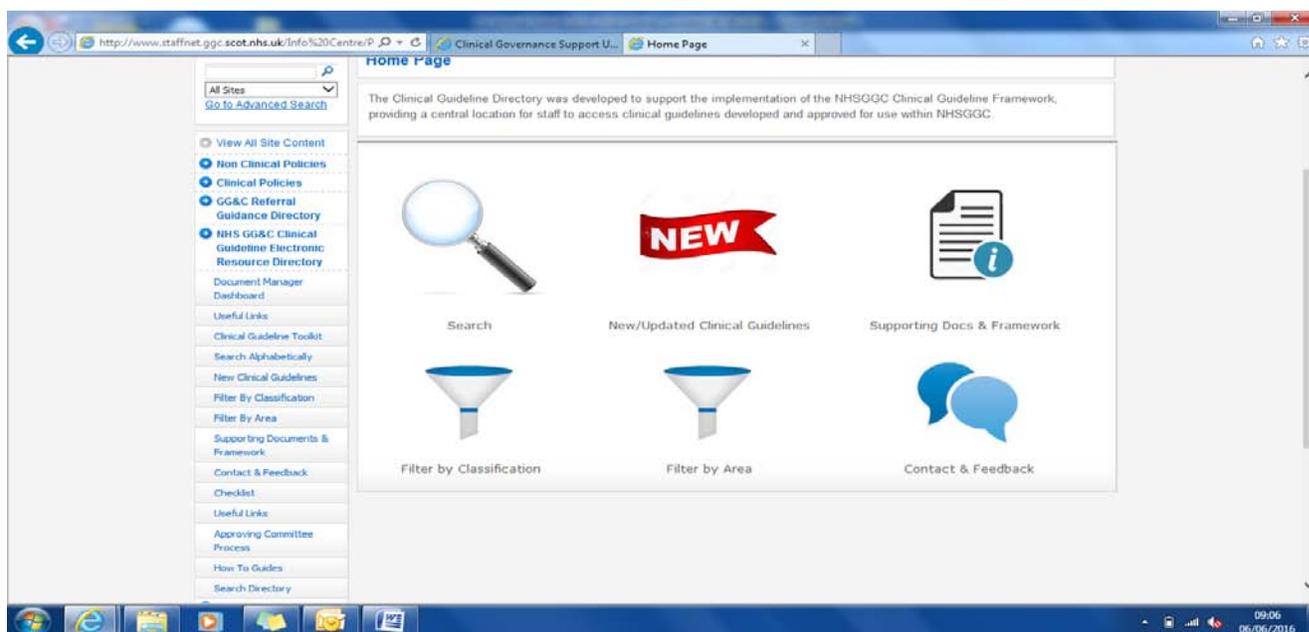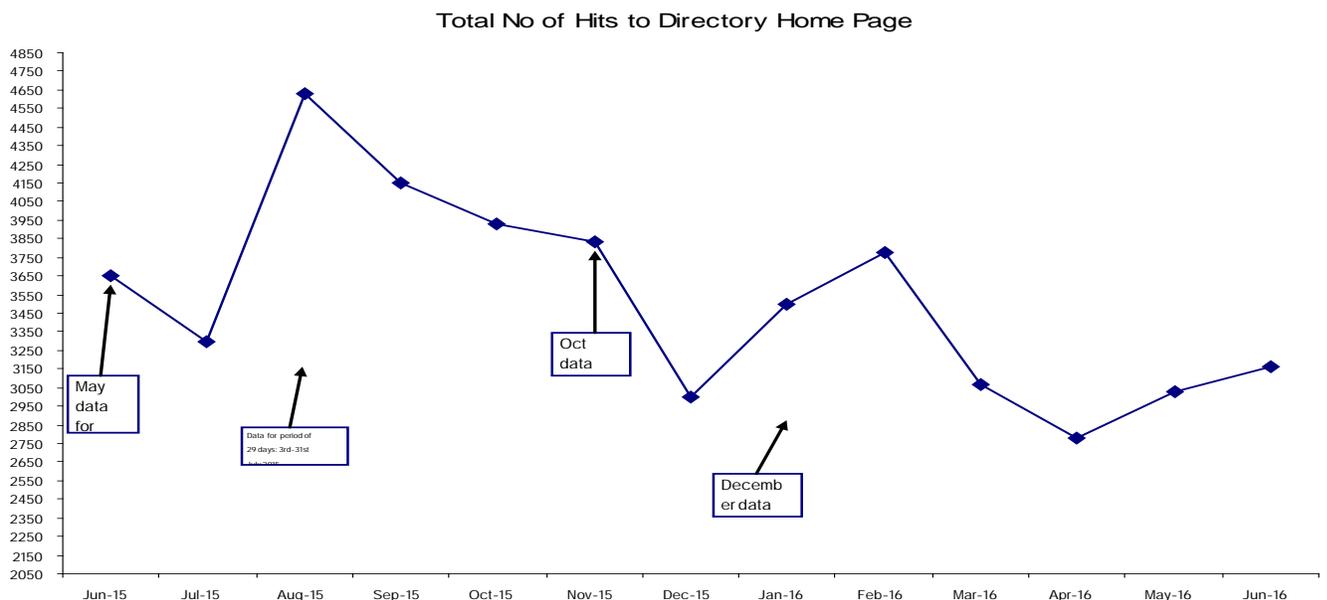
6.2.3   Clinical Guideline Activity

341 clinical guidelines (Chart 5) have been successfully uploaded onto the Clinical Guideline Directory, and the majority of those guidelines remain current and valid (98%) for clinicians to use to support clinical decision making.

Chart 5 NHSGGC Number of Clinical Guidelines Uploaded to the Guideline Directory

Guidelines uploaded onto the Directory

Legend: 2014-2015, 2015-2016

Category	2014-2015	2015-2016
New	88	106
Migrated - Clinical Info	91	84
Migrated - Directorate	109	151

X-axis: **Total Number per reporting period**
Y-axis: **Number**

6.2.4   Clinical guideline activity is reported bi-monthly to the Acute Services Division Clinical Governance and Board Clinical Governance Forum, and to key Clinical Governance Groups/Forums across the Sectors/Directorates and Partnerships. From April 2015 to March 2016 there have been on average 124 hits to the directory home page per day, from 64 distinct users. On average, there are 3000 hits to the Clinical Guideline Directory home page each month.

Chart 6 Number of hits to the Guideline Directory/month

Total No of Hits to Directory Home Page

May data for

Data for period of 29 days: 3rd-31st

Oct data

December data

6.2.5   The Top 10 Clinical Guidelines accessed via the Clinical Guidelines Directory

No	Guideline Title	No hits in June 16
1.	Gentamicin dosing calculator adults	**2081**
2.	Vancomycin dosing calculator, adults	**694**
3.	Empirical antibiotic therapy, infection management, adults	**300**
4.	Delirium, prevention, diagnosis and management	**138**
5.	Heparin dose adjustment, adult patients with very high or low body weight	**131**
6.	Infection management in adults guidance for primary care	**129**
7.	Vitamin D, blood measurement and treatment, patients with osteoporosis and osteomalacia	**124**
8.	Atrial fibrillation management	**117**
9.	Apixaban, treatment of deep vein thrombosis and-or pulmonary embolism.	**104**
10.	NHSGGC management of occupational and non occupational exposures to blood borne viruses	**103**

6.3   Clinical Quality Publications

6.3.1   In 2013 NHSGGC recognised the need to create a standardised process for reviewing and tracking of impact assessment of clinical quality publications relating to NHSGGC care processes. A standard operating procedure and supporting systems were tested from January 2014, and reviewed and refined during 2015.

6.3.2   Following large scale organisational change in June 2015 the process and system was reviewed and updated to reflect the changes both at an organisational and departmental level. The result of this was a centralised and more streamlined process.

6.3.3   The process creates a standardised approach to the way Sectors/Directorates and Partnerships review, respond, and report following the publication of clinical quality reports. Members of the Clinical Effectiveness Team liaise with Sectors/Directorates and Partnerships to identify the person(s) most appropriate to impact assess the publication, the clinical impact assessors are asked to carry out an impact assessment within 3 months of publication.

6.3.4   Since launching in 2014, 60 clinical quality publications have been identified as applicable for reviewing and tracking. 50 of these have been reviewed and determined as closed; the remainder are still in the process of being impact assessed. Often the clinical quality publications relate to national audit processes.

> The reviewing and tracking process for clinical quality publications supports clinicians and managers to review the results and to consider any actions to be taken. A summary is then collated impact assessment is produced by Clinical Effectiveness Team and is reported to key Clinical Governance Groups/Forums across the Sectors/Directorates and Partnerships, and then to the Acute Services Division Clinical Governance and Board Clinical Governance Forum, thereby supporting corporate assurance processes.

6.4   Clinical Governance Related Guidance

6.4.1   The Clinical Effectiveness Team's role involves:

- Maintaining a system across NHSGGC for tracking and reporting the impact assessment process for the following publications:

  - Scottish Intercollegiate Guidelines (SIGN)
  - National Institute for Clinical Excellence Interventional Procedures (NICE IPG)
  - Healthcare Improvement Scotland Standards (HIS)
  - Healthcare Improvement Scotland HIS Clinical Quality Indicators (HIS)

> April 2015 – March 2016
>
> - Developed and improved the process for tracking impact assessments of newly publication national guidance, including National Institute Clinical Excellence, Scottish Intercollegiate Guidelines Network and Healthcare Improvement Scotland Standards and Clinical Quality Indicators and other clinical quality publications.
> - 90 publications have gone through the process of impact assessment, tracking and reporting in 2015-2016.

- Dissemination of a monthly newsletter highlighting all new clinical governance related guidance which the NHSGGC Policy for Addressing Clinical Governance Related Guidance covers. This is e-mailed out across NHSGGC to a core distribution list and made available via the CGSU Intranet site. Informal feedback from Clinical Leaders advises that this is a very useful summary and helps them to keep abreast of new publications.

- Emailing a notification of the publication of new guidance to a core distribution list using standard communication processes. This email outlines the organisational response expected as outlined in the NHSGGC Policy for Addressing Clinical Governance Related Guidance.

- Ensuring that new guidance is impact assessment within 3 months of publication through an agreed process. The outputs of this are reported to the Acute Services Division Clinical Governance and Board Clinical Governance Forum, and to the key Clinical Governance Groups/Forums across the Sectors/Directorates and Partnerships.

6.4.2   Chart 6: Clinical Governance Related Guidance Published April 2015 to March 2016
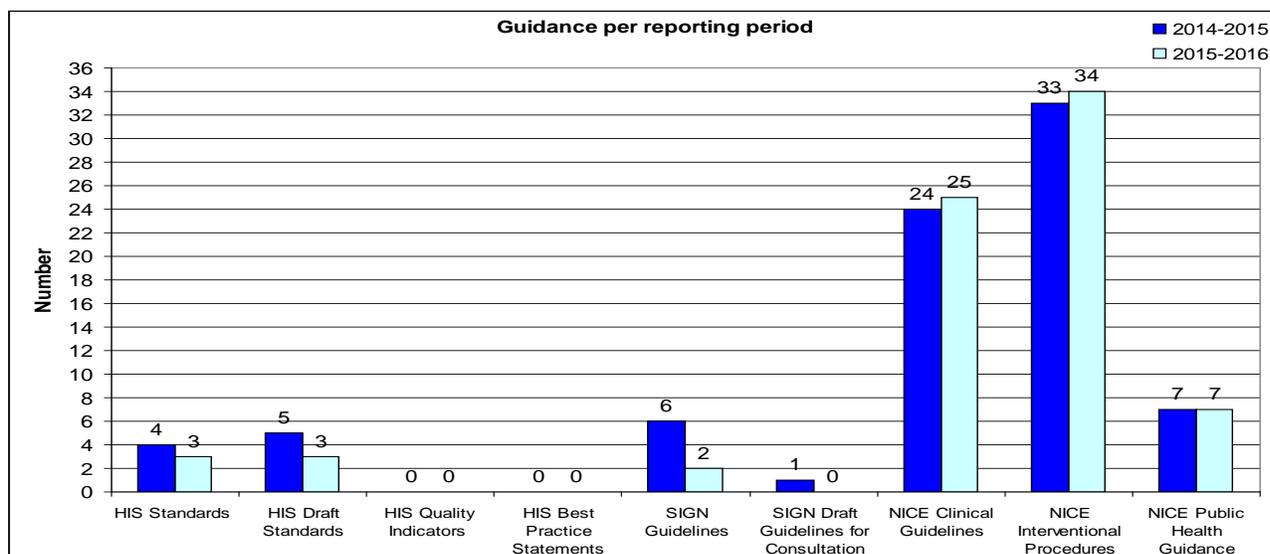
6.5   Developing Quality Improvement Capacity and Capability

6.5.1   In September 2013, the Acute Services Division of NHSGGC endorsed the proposal to change from clinical audit to the model for improvement (MFI) as the preferred choice of improvement approach.

6.5.2   A quality improvement workshop was developed by the Clinical Effectiveness Team and 7 one day quality improvement workshops have taken place between April 2015 and March 2016 with clinical staff 222 delegates attending.

> **Next steps towards Building QI capability from April 2016**
>
> - Quality Improvement workshop for pharmacy staff took place on 20th April 2016
> - Quality Improvement workshop for Mental Health took place on 28 April 2016
> - Quality Improvement workshop for Clinical Leaders took place on the 3rd May and the 2nd June 2016, and a further two sessions are planned for later in the year
> - Quality Improvement workshop for Partnership staff took place on 31st May 2016
> - Allied Health Professionals Quality Improvement Development Programme is in the early stages of discussion with the Director for Allied Health Professionals.
> - Awareness Raising sessions on QI methodology have been incorporated into the Nursing & Midwifery "Making a Difference" Development Programme and will be delivered during July and August 2016.

6.5.3   Evaluation of Quality Improvement Workshops

- The workshops continue to evaluate very well, and are consistently fully booked, with a waiting list in place.
- 100% delegated agreed that the workshop increased their knowledge of quality improvement
- 77% of attendees stated that they intended to use the learning to undertake a quality improvement project within their own area.

6.5.4   On average pre and post knowledge scores increased from know **what** (pre workshop) (score 2) to **know how, when and where to use** (score 4) following attendance at the QI workshop.
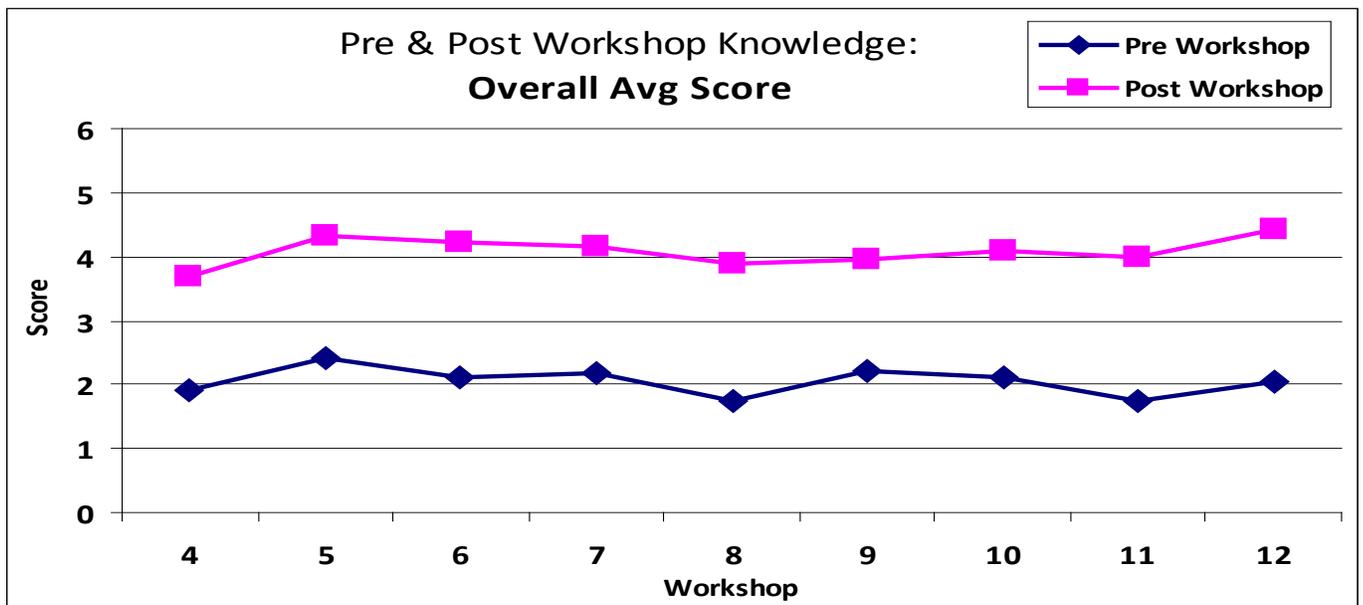
6.5.5 Recent developments include the testing and implementation of a coaching for improvement support programme for all QI workshop attendees to support and encourage QI project progression. All attendees at workshops are offered the opportunity to work with an improvement coach for 6 months. Further work is being undertaken to develop a framework for coaching, to ensure a standardised approach.

6.5.6 A number of 'How To' guides for Quality Improvement have been developed. These can be used both as an additional resource for delegates attending the workshops, or as stand alone guides for each of the topics covered in the curriculum.

6.5.7 Tailored QI training has been delivered to increase QI capability in medical wards at Inverclyde Royal Hospital (IRH). The model used was then replicated at the Royal Alexandra Hospital (RAH) to support clinical teams to deliver rapid improvements in clinical areas and participation in the deteriorating patient work stream.

6.5.8 Access to National Programmes to Build QI Capability and capacity

- 15 clinical staff in NHSGGC have completed the Scottish Patient Safety Fellowship Programme
- 3 staff in NHSGGC have completed the Scottish Improvement Leadership Programme (ScIL) and a further 2 are part way through the programme.
- 9 staff in NHSGGC have completed the Institute for Healthcare Improvement Advisors (IA) Development Programme

6.6 Quality Improvement Project Activity

6.6.1 As indicated in previous annual reports, there has been a continuous decline in the number of projects the clinical effectiveness team are being asked to support. Within the Acute Clinical Effectiveness Team, project activity during 2015-2016 remained low, with around 20 projects being actively supported at a time. It is believed that the decline in activity is associated with the large scale organisational change, and the other range of quality improvement initiatives being undertaken within the acute setting, e.g Scottish Patient Safety Programme.

6.6.2 Within the Partnerships Clinical Effectiveness Team, 116 projects have been supported during 2015-2016 .This figure can be broken down into the following:

- o 57 new projects started
- o 45 projects completed
- o projects abandoned
- o on-going projects

6.6.3 A centralised approach to the allocation of new work was developed, ensuring that all new work requests are supported consistently, and that work is directed to the right person/ team who has the skill/knowledge and capacity to support the work. There are two QI project discussion forums established in for acute and partnership projects.

6.7 Improvement Project Examples

Community District Nurse Team – Implementation of Malnutrition Universal Screening Tool (MUST)

The Malnutrition Universal Screening Tool (MUST) has been successfully implemented within NHSGGC Partnership areas of Community District Nurse teams, Rehabilitation teams and Older Adults Mental Health Teams. This implementation supported by Food Fluid and Nutrition Community Operational Group was achieved through staff training, evaluation of the process and feedback from staff. During the evaluation it was recognised that with an increase in service demand and more complex community caseloads a Healthcare Support Worker is often the first person a service user will come into contact with in the community, thus they are ideally placed in identifying malnutrition risk. Using the model for improvement, a MUST competency framework was developed and tested. These 10 competencies, which encourage experiential and reflective learning techniques have been well received by staff.

V Flag Outcome Measure

An outcome measure for the VTE work stream has been developed in collaboration with the Diagnostics Directorate, whereby a flag (V) is added to any CTPA or upper leg dopplers performed and found to be positive for VTE. At present, this system is flagging an average of 100 patients per month (38% less than the expected number). A manual process is undertaken to check if events are associated with hospital stay within 90 days. This process is identifying that 28% of events maybe associated with a hospital stay.

Evaluation of the Single Tooth Anaesthesia System (STAS) Wand in patients with Chronic Bleeding Disorders (CBD)

The Wand® Single Tooth Anaesthesia System is a safe and effective method of anaesthetising lower molar teeth for restorative treatment in patients with congenital coagulopathy. Traditional methods for anaesthetising lower molar teeth for restorative treatment mean the administration of appropriate prophylaxis in advance of the procedure for patients with bleeding disorders. Administration of an inferior alveolar block without appropriate prophylaxis may cause soft tissue bleeding, swelling and possible airway compromise. The Wand delivers local anaesthetic solution directly to the periodontal ligament by an intraligamental injection. No prophylaxis is necessary. The depth of anaesthesia is comparable to that achieved by an inferior dental block.

Twelve patients with chronic bleeding disorders were recruited to complete the questionnaire post treatment. The evaluation identified savings associated with the use of the Wand, with 6 patients who did not require DDAVP, resulting in an estimated saving of £400 per patient; in addition, 1 patient did not require 3000 units at a cost of £1500. The total amount saved was £25,500. This method of anaesthetic could possibly be used in other areas of medicine.

6.8 Nursing, Midwifery & Allied Health Professionals Directorate (NMAHP)

6.8.1 Introduction

The NMAHP Directorate was formed by the Board Nurse Director in June 2015 as a result of the reorganisation of NHSGGC to:

- establish NMAHP Strategic Direction
- ensure Policy development & compliance of Standards
- support Sectors/Directorates execute strategy and manage risk.

There has been a focus on the following key workstreams during the past 12 months:
1. Best Care for Older People (referenced in the clinical governance section 2 of this report)
2. Care of patients with Delirium
3. Meeting requirements of Adults with Incapacity
4. Making a Difference
5. E-health

6.8.2   Delirium

Delirium although common in hospitalised older people, particularly those with dementia or cognitive impairment, should be considered a hospital acquired harm and be associated with a variety of adverse outcomes. Delirium represents an acute dysfunction of the brain and often has multiple causes. Optimal management of delirium relies on prompt diagnosis and comprehensive assessment to ensure delirium is diagnosed and patients are treated appropriately. From July 2016 all patients at risk of delirium are screened by nursing staff on admission and at each transition of care using the 4AT. Patients with a positive 4AT score will be referred to medical staff who will complete the TIME checklist to confirm the diagnosis of delirium and document the management plan in medical notes. Patients with a negative 4AT will still have relevant parts of the TIME checklist completed in order to reduce the risk of the patient developing delirium. For all patients nursing staff will ask the Single Question in Delirium (SQiD) daily, using a prompt in the care rounding/active care documentation. A Delirium podcast has been developed and is available on the NHSGGC website. A Delirium Patient and Carer HIS Leaflet and 'THINK DELIRIUM' posters have been printed for all clinical areas.   A toolkit has been developed to support implementation of the Delirium Guideline and summary document and is available via Staffnet.

Ongoing monitoring arrangements will see review of this process as part of SCN/Lead Nurses record and record keeping audits and through corporate unannounced OPAH inspections. It is proposed that all cases of hospital acquired delirium are reported as part of the Performance Review (PRG) and recorded on NHSGGC clinical incident reporting system DATIX.

6.8.3   Adults with Incapacity

To mark national dementia week and What Matters to Me day NHSGGC launched new paperwork to support capacity assessment and the appropriate use of the Adults with Incapacity act including documentation and discussions for those who lack it. This is required by law and by the GMC's Duties of a Doctor. The new paperwork protects our most vulnerable patients and encourages healthcare staff to   trigger conversations with Families, Next of Kin, Welfare Power of Attorney or Welfare Guardian where capacity to consent for medical treatment is being assessed.

An AWI staffnet page and AWI Webex is available for all staff. All acute hospital sites have received key messages around the launch of new AWI Capacity Documentation. Further work is underway to support the rollout of the documentation and to provide local awareness training for staff.

6.8.4   Making a Difference

Making a Difference is a 2 –day management programme aimed at band 5 – band 8A nursing and midwifery staff commissioned by the Board Nurse Director. Nurses and midwives can make a significant contribution to NHSGGC objectives of improving quality to enhance patient safety and people's experience of services. They can also contribute to the reduction of financial spend by reducing levels of sickness absence, levels of nurse bank shifts and effective roster management. Developing management capabilities and capacity across the organisation is key and integral to these objectives This 2 day programme encompasses the practicalities of improvement methodology, workforce planning, nursing and midwifery regulation, patient centredness and fundamentals of care. Ongoing sustainability will be formalised through action plans monitored by the Sector Chief Nurses. The programme is supported by a rolling programme of 'Spotlight sessions' hosted and subject area master classes hosted by the board Nurse Director Resources from the sessions will be hosted on the NHSGGC Nursing and Midwifery pages.

6.8.5 E-Health

The development of electronic nursing documentation is imperative in providing an effective and modern record of assessment and care planning for nurses as part of the electronic patient record.
The fundamentals of record and record keeping practice must be explicitly described within the development of an electronic record and the specification for an electronic system must include all the elements which meet NMC Record and Record Keeping Standards.

Review of record and record keeping by local and corporate audits demonstrate that practice remains inconsistent and does not meet the required standards. A Chief Nurse/Midwife session took place to develop e-health workshops supported by Organisational Development. This workshop will focus on two key pieces of work to progress simultaneously as part of the development of an electronic nursing care and assessment record, these are:

1. Review of existing nursing documentation
2. Process mapping activity

A half day workshop for Lead Nurses and Senior Charge Nurses (n-27) held on 22nd June 2016 shared planned strategic approaches to eHealth in NHSGGC. An overview of existing eHealth systems available to N&M teams throughout the patient journey/pathway from front door to discharge including internal and external transfers and covering all specialties using process mapping techniques was addressed. OD will supply workplace support for process mapping. A second event is planned on 24th August to overlay these processes with wider engagement which will include Band 5s and Band 6s.

Plans are afoot to embed eHealth in undergraduate programmes, a national position statement will be issued around this as engagement is underway with eHealth Leads, NES and Scottish HEI Deans

A NMAHP eHealth Leadership Programme, led by NHS Education for Scotland, supports ambitious, experienced nurses, midwives and allied health professionals to influence eHealth and demonstrate innovation and creativity in leading change for the benefit of patients. Nurses, midwives and allied health professionals (NMAHPs) are at the forefront of an evolving health and social care system which has seen eHealth emerge as central to improving quality service provision in Scotland. NMAHPs require enhanced leadership skills and technological competence in order to provide eHealth solutions to enhance safe and effective person centered care, and influence the eHealth agenda at local and national levels.

A scoping exercise looking at what service require from a Care Assurance' dashboard has been commissioned. A project lead has been appointed to develop a prototype utilising MicroStrategy software for initial testing by clinical service users. Additionally meetings have taken place with the CAS expert development Chairs to ensure synergy between the data currently collected electronically within service and will be now be reported via the dashboard with data required in CAS assurance documentation with the primary aim to reduce the volume of written evidence and duplication of data collection to reduce the burden on clinical teams.

6.9   Conclusion

During 2015-16, the £842 million state-of-the-art Queen Elizabeth University Hospital (QEUH), the Royal Hospital for Children (RHC) and the Queen Elizabeth Teaching and Learning Centre was opened on time and within budget. The represents Scotland's biggest ever hospital building project. In addition, the new Health and Social care partnerships were developed.

There were therefore significant changes both in the acute, mental health and primary and community care services and structures. This required a review of the clinical governance arrangements for the board. As this annual report demonstrates, clinical governance has a high profile within the organisation with a clear focus on providing excellent services and learning from adverse events to ensure we get it right for every patient.

Staff across NHSGGC, together with carers and patients, have made been very successful in continually improving the clinical care and experience for our patients. We must continue to do this and there are a range of areas which we require to progress over the coming year and they include:

1.   Accelerating the implementation of key programmes to enhance patient safety and patient experience across the system.
2.   Improving the dissemination and sharing the learning from serious clinical incidents across the organisation.
3.   Developing effective teams with quality improvement capability throughout the clinical services to provide continuous improvement in clinical care.
4.   Incorporating performance and outcome measures for improvement and accountability.
5.   Making effective use of information technology to improve the availability of data for clinical outcomes and improvement.
6.   Ensuring that clinical services have up to date evidence and guidelines in place to provide high quality care.
7.   Ensuring that the new structures in place provide assurance to the board and ensure there is an awareness of the key clinical risks.
8.   Learning and implementing any recommendations from external and internal quality reviews.
9.   Review the various quality workstreams within NHSGGC to ensure that they work in the most effective way to enhance patient care.

In the autumn, it is our intention to bring together a large range of stakeholders to develop our approach to clinical governance and quality.