NHS Greater Glasgow & Clyde

NHS BOARD MEETING

Medical Director/Nurse Director **27th June 2017** **Paper No: 17/27**

Clinical & Care Governance: Overview Report

Recommendation:-

The NHS Board is asked to:

- Note the key messages,
- Advise on areas where further assurance may be required.

Purpose of Paper:-

This report has been developed to provide a short, illustrative summary of clinical governance as a basis for assurance for the key oversight groups. It should be noted there is a large range of more detailed reports being reviewed in the local clinical governance forums.

Key Issues to be considered:-

There are brief updates on the operation of

- Person Centred Care, including major themes from service user feedback and updates on improvement activities
- Clinical Safety, noting the revision and publication of two key policies
- Progress in developing and implementing the Mental Health Patient Safety Programme
- A report of the work of GG&C Thrombosis Committee to improve prevention, diagnosis and treatment of venous thrombosis (primarily pulmonary embolism [PE] and deep vein thrombosis [DVT]) across the Health Board

Any Patient Safety /Patient Experience Issues

Yes.
Parts of this report relates to the 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

and the supporting objective

  - making further reductions in avoidable harm and in hospital acquired infection;

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Greater Glasgow and Clyde NHS Board

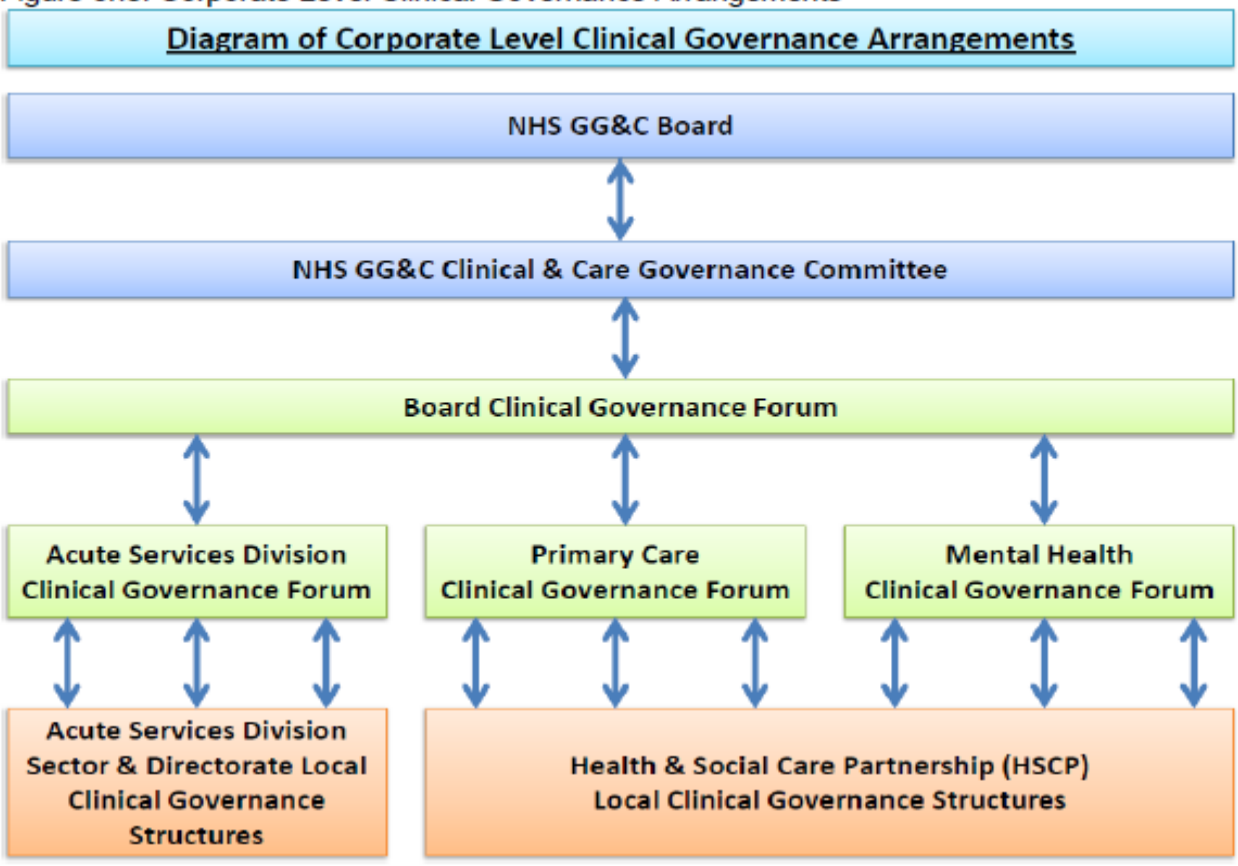
CLINICAL AND CARE GOVERNANCE: OVERVIEW REPORT (up to May 2017)

Introduction

The Health Act 1999 requires that NHS Greater Glasgow & Clyde (NHSGGC); "put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals."

NHSGGC must satisfy this duty of quality through maintenance of dedicated arrangements, which includes effective collaboration with partner organisations. The Clinical Governance arrangements within the Board have been set up to meet the Boards statutory "Duty of Quality". (Figure one)

Figure one: Corporate Level Clinical Governance Arrangements



This report has been developed to provide a short, illustrative summary of clinical governance for the key oversight groups. It should be noted there is a large range of more detailed reports

being reviewed in the local clinical governance forums. These are collectively structured around the main domains of clinical quality and governance, set out in NHS Scotland National Quality Strategy, as follows:

1. Clinical Safety
2. Clinical Effectiveness
3. Person Centred Care
4. Clinical Governance system and leadership

This report is limited to a description of key points on progress and challenges arising from a sub-set of more extensive activities across the clinical governance arrangements. As part of corporate assurance for clinical governance a form of this report is initially considered at the meetings of the Board Clinical Governance Forum. A developed version is then provided to each of the quarterly meetings of the Clinical and Care Governance Committee and meetings of the NHSGC Board.

This report focuses on an overview of

1: Patient and Carer feedback received between December 2016 and January 2017
2: Person Centred Health and Care Programme
3: Clinical safety. an update on the renewal of two critical policies
4: NHSGGC Mental Health Safety Programme
5: NHSGGC Thrombosis Committee Report

The Board of NHSGGC is asked to;

- Note the key messages,
- Advise on areas where further assurance may be required.

1. Patient and Carer Feedback

This section details known patient feedback provided from December 2016 and January 2017. It includes:

1. An overview of positive and negative feedback from the three centrally supported methods of feedback.
2. Analysis of the key themes from the three centrally supported methods of feedback.

Overview of Known Feedback
In line with our requirements under the Patient Rights Act, NHSGGC seeks and welcomes feedback from all patients, carers and other users of our services. There are three centrally supported methods of feedback that complement that gathered by teams or departments locally; these are:

- Universal Feedback
- NHSGGC Patient Feedback
- Care Opinion (formerly known as Patient Opinion).

Overall, 88% of the total feedback received in the period December 2016 to January 2017 was positive.

Key Themes of NHSGGC Patient Feedback

Across all three methods, positive feedback is overwhelmingly about staff, particularly in terms of how well they interact with patients and carers, with descriptions such as professional, friendly, kind and helpful frequently used.

There is also an increase in the amount of feedback commenting specifically on positives about the services provided, particularly when people feel they have been treated efficiently and with ease.

The leading area for improvement remains communication, reflecting both clinical communication (e.g. improving the way teams communicate the treatment plan to a patient) administrative communication (e.g. quality of information provided in letters).

The number of negative comments related to Facilities continues to decrease: parking problems and smoking on the hospital grounds are no longer the leading themes this period.

2. Person-centred Health and Care Programme

Background
The Person-Centred Health and Care (PCHC) Programme Team gathers in-depth care experience feedback in “real-time” from people whilst they are receiving care using a ‘themed conversation’ approach. This also includes relatives and/or carers where they are available.

The cohort of care teams involved are all within the Acute Services Division (ASD). The programme of work at present includes three defined groups:

1. Core Programme (individual care teams spread across ASD Sectors/Directorates)
2. Medical Pathway (Glasgow Royal Infirmary)
3. Maternity Pathway (Queen Elizabeth University Hospital and Royal Alexandra Hospital, Paisley)

Progress Update
In April 2017, a total of one hundred and two (102) 'themed conversations' were held in twenty-six (26) care teams to gather "real-time" feedback.

The overall aim is to achieve an aggregated positive care experience response of 95% and above in all care teams. The aggregated positive care experience response for the person-centred core programme (individual care teams) is 96%, medical pathway (GRI) is 88% and for the maternity pathway (QEUH & RAH combined) is 91%.

Four predominant themes continue to emerge from the feedback demonstrating what contributes to a positive care experience, what adds value, what does not add value and where inconsistency and variation arises. These themes are consistent with other forms of feedback received in NHSGGC: consistency and coordination of care, communication and involvement in care, and privacy whilst receiving care. These are issues the clinical teams are actively improving.

A few examples of improvements plans in a selection of the care teams.

"What matters to you?" – a number of care teams are developing a conversational approach to find out what is most important to people, on a daily basis in relation to their plan of care and using this information to update 'what matters to you' boards and integrating this information into MDT rounds and conversations to inform future goal setting and planning.

"Who matters to you?" – the MDT in ward 56 in the Langlands Unit at QEUH are proactively phoning relatives after the main ward round to update the nominated relative/carer on progress made, the forward plan of care and provide the opportunity for queries and questions.

"What information do you need?" – senior charge midwifes and community midwifes at QEUH have mapped information given to women across the pathway of care with an aim of streamlining what information is given at which point of care and ensuring information is given at the right time, in the right format and to identify any current gaps in the information flow. There is a secondary aim to reduce the amount of un-necessary duplication of information given.

Nothing about me, without me (involvement) – staff in A&E and AAU at GRI have introduced an approach named 'stay with me' to ensure that people in a caring role remain with the patient to help support communication and information exchanges and are involved in decision about the initial plan of care.

Personalised contact – clerical staff in the medical receiving unit at GRI are phoning the nominated relative or carer (within core working hours) to inform them when people are being transferred to a downstream medical ward with the aim of improving communication processes and keeping relatives/carers up-to-date of planned transitions of care.

3. Clinical Safety

"Clinical risk management specifically is concerned with improving the quality and safety of healthcare services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risks". (World Health Organisation Patient Safety Guide)

The following simple four-step process is commonly used to manage clinical risks:

1. Recognise and report adverse events leading to patient harm;
2. Review events (using Root Cause Analysis) to identify how harm could be prevented;
3. Implement changes that can improve that safety of clinical care;
4. Monitor the progress in reducing clinical risk.

In NHSGGC clinical incident reports are made through an electronic system (Datix). There is a tiered approach to incident review with the most robust investigation undertaken for events falling within the definition of Significant Clinical Incidents. Each (SCI) investigation is tracked from the initial report through a managed process to confirmation that any resulting actions are complete.

Publication of the NHSGGC Significant Clinical Incident Policy

The management of a Significant Clinical Incident (SCI) forms part of the current Clinical Risk Management arrangements and should be recognised as an important means of improving the quality of patient care and minimising risk. It is the policy of NHSGGC that a robust investigation will be conducted into all Significant Clinical Incidents. The purpose of the investigation is to determine whether there are learning points for the local services and the wider organisation. It is then our responsibility to implement those improvements that we identify and so produce a greater level of clinical safety for our patients.

The SCI policy has been in place since 2008 and is reviewed every 3 years. The policy has been subject to review and consultation. For example has been reviewed against national guidance that has been issued for health professionals in Scotland and complies with:

- Health Improvement Scotland – Learning from adverse events through reporting and review: A national framework for Scotland (2015)

- Health Improvement Scotland – Being open in NHSScotland: Guidance on implementing the Being Open principles (2015)
- GMC & NMC - Openness and honesty when things go wrong: the professional duty of candour (2015)
- Duty of Candour principles in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (2016)
- Letter from Scottish Government re: Learning from Adverse Events (27 March 2017)

As a result of the review and the consultation the opportunity to improve the policy has been taken to include:

- A description of the screening process to select potential SCIs
- Duty of candour legislation has been anticipated as far as possible and is now explicitly referenced
- Examples of what constitutes an SCI have been updated to reflect more recent trends.
- The escalation and communication process has been updated to ensure broader awareness
- Outcome codes have been renamed “investigation conclusion code” to avoid confusion with patient outcome and descriptors updated to provide clarity on meaning.
- The commissioning stage has been reinforced to include the consideration of joint investigations (for both Acute and HSCPs)
- Creation of a specific requirement that in the event of a delay in completing an SCI investigation the family should be contacted with reasons (as a result of feedback from families).

The new policy was approved at the April 2017 meeting of the Board Clinical Governance Forum. The policy is being published via Staffnet and through existing distribution channels.

There is a toolkit, available in Stafnet, which accompanies the SCI policy and this has also been updated to include:

- Guidance on recommendations and action planning.
- A guide to incidents mentioned within complaints.
- Guidance for communication with patients / families including letter templates.
- A FAQ section.

Publication of the NHSGGC Consent policy on Healthcare Assessment, Care and Treatment

This policy aims to inform staff of NHSGGC of the principles of consent; to ensure that the ethical and legal requirements relating to consent are adhered to in practice, and to ensure that valid consent is obtained from patients prior to any treatment, investigation or examination.

Over recent months the policy has been subjected to a consultation process and been reviewed against national guidance that has been issued for health professionals in Scotland with implementation of some of this in progress such as :

- SPSO Informed consent, Learning from Complaints (March 2017, the 14 case studies benchmarked against this revised policy).
- Chief Medical Officer, Realistic Medicine Feedback report (2016).
- The Royal College of Surgeons, Consent: Supported decision- making – A guide to Good Practice (Nov 2016).

- The Mental welfare Commission, Good Practice Guide: Supported Decision Making (Nov 2016).

There were no fundamental changes to the policy, though we have enhanced guidance for staff around the Montgomery Ruling in 2015 regarding considering relative risk within each informed consent discussion. The Supreme Court Ruling in Montgomery (2015) endorsed a new test for consent which requires a health care professional to take into account an individual's circumstances and preferences when explaining a treatment, and to consider what risks this particular patient would be likely to consider as significant. The Montgomery Ruling fundamentally changes the nature of the relationship between patients and healthcare professionals, empowering patients to take an active role in their healthcare. This policy review has also has integrated the good practice principles and the self assessment checklist as outlined in the above SPSO publication.

The new policy was approved at the April 2017 meeting of the Board Clinical Governance Forum and is being published via Staffnet and through existing distribution channels. The publication of this policy will be an agenda item at all Clinical Governance meetings over the next quarter and a series of seminars will be hosted across all hospital sites.

4. NHSGGC Metal Health Safety Programme (Linked to SPSP)

The local programme was initially established as an early pilot for Scottish Patient Safety Programme (SPSP) in Mental Health in two wards in 2012. In 2013 the Leadership and Culture work-stream was developed in the form of Staff and Patient Safety Climate Surveys.

The patient survey results highlighted that patients were not always clear of the side effects of their medication. As a result of these Patient Climate Survey results, consideration is being given to developing interventions to improve the safety of high risk medicines and to improve the medicines aspect of the discharge process.

At the start of 2016 all 15 adult acute mental health wards were supported to improve the risk assessment process, improve communication between teams and improve medicines management. The aim was for each ward to demonstrate sustained reliability in maintaining the clinical process e.g. each patient had a risk assessment completed, in partnership with the patient within 2 hours of admission to hospital and is updated at each multi disciplinary team meeting. The wards must show more than 95% of the practice is being performed for 9 consecutive months to demonstrate compliance.

Mental Health staff have made good progress in developing and testing the requirements for each set of practices (i.e. bundle) and then embedding them in routine of the clinical team. For instance the mental health clinical risk assessment is supported by a bundle of required practices that are deemed to be related to a safer care process.

Risk Assessment Bundle

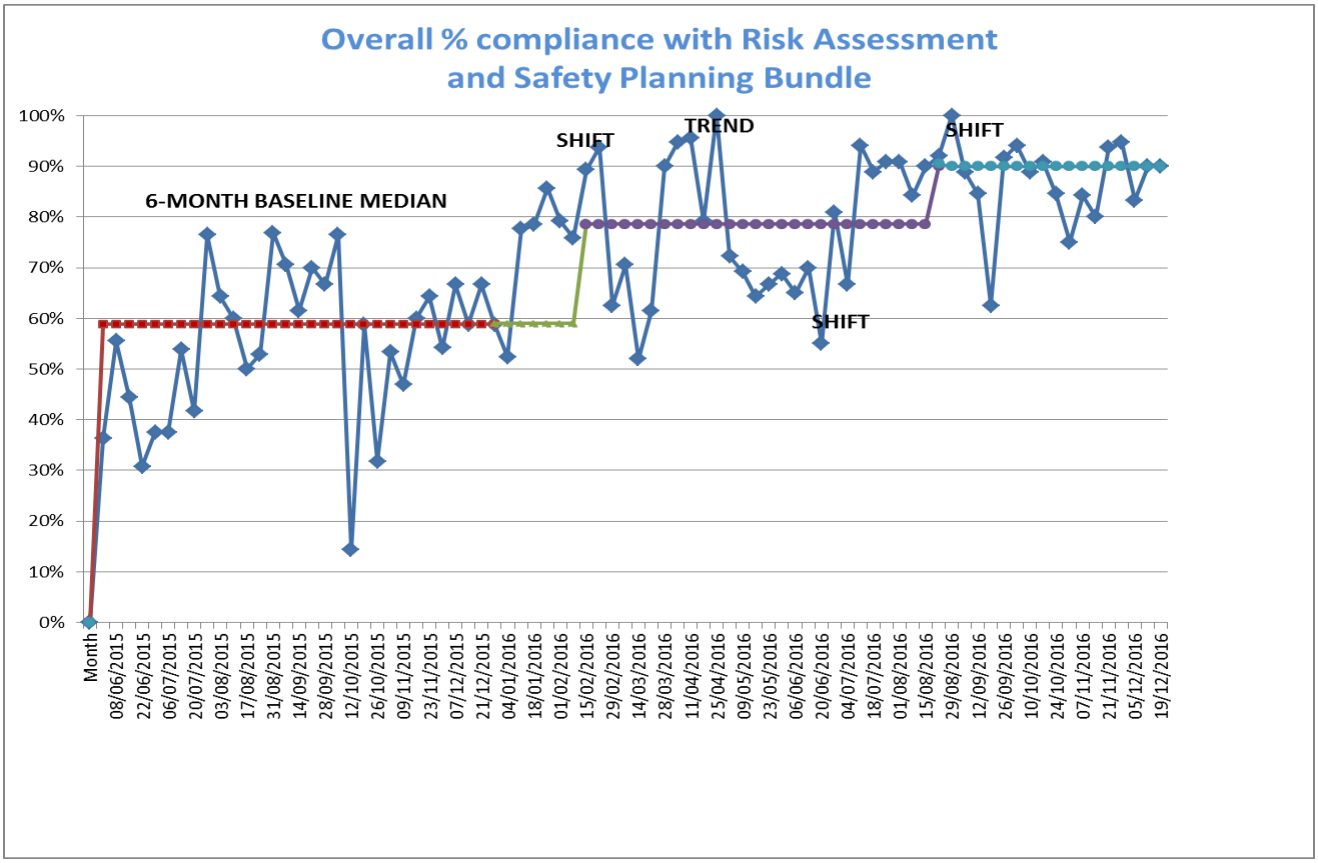
- There is evidence that the Initial risk assessment and management plan was in place within 2 hours of admission
- There is evidence that the risk assessment and management plan have been developed in partnership with service user, carer and multidisciplinary team including

service users preference

- There is evidence that the risk assessment includes known historical and current triggers for harm and evidence of positive risk taking
- There is evidence the Individual management plan includes actions to reduce current triggers and monitor historical triggers
- There is evidence the updated risk assessment and management plan was discussed at first MDT
- There is evidence that the patient risk assessment was discussed at multidisciplinary team meeting.

From 2015 to 2016 overall reliability with the Risk Assessment bundle increased from 59% to 90% (chart one). Four wards have demonstrated sustained reliability of over 95%.

Chart One: Overall % compliance with Risk Assessment and Safety Planning Bundle



6. NHSGGC Thrombosis Committee

Background

The NHSGGC Thrombosis Committee was formally established with the aim of ensuring common practices for prevention, diagnosis and treatment of venous thrombosis (primarily pulmonary embolism [PE] and deep vein thrombosis [DVT]) across the Health Board. The full 2016 Report of the NHSGGC Thrombosis Committee was recently considered in the NHSGGC Clinical Governance arrangements and a summary is presented here.

Guidance

An important way of supporting best clinical practice is through the publication of clinical guidelines. The NHSGGC Thrombosis Committee provides six chapters in the Prescribers Handbook (App) relating to venous thromboembolism prevention, diagnosis & treatment, and Management of anticoagulation around surgical procedures. In addition, the committee has developed or facilitated a further 18 focused guidelines which are held on the Clinical Guideline Electronic Resource Directory on StaffNet.

The committee has also facilitated the development of several patient information leaflets relating to VTE prevention, offering advice prior to, and at, hospital admission and also on discharge – empowering the patient to be aware of the risks of VTE and their own role in prevention. A series of leaflets is also available for those patients being investigated and managed in an ambulatory setting, for suspected DVT or PE.

Quality Improvement

NHSGGC have been working on the Scottish Patient Safety Programme VTE Prevention Workstream and across the Acute Services Division 27% (34/125) of applicable wards are currently/have been active in this workstream. The key aims are that all relevant patients are: (1) assessed for their risk of developing VTE, and (2) appropriate thromboprophylactic measures are administered.

Our experience to date has identified what works well:

- standardisation of process, including the use of a risk assessment tool for VTE
- active and engaged clinical leadership
- checks and reminder systems at ward rounds and handovers
- data collection and monitoring made easier
- well managed accountability and reporting structures
- dedicated Clinical Governance Support Unit (CGSU) improvement support

Indeed, through 2016 there has been a steady improvement in overall compliance and achievement of these measures, however there is still further opportunity improving risk assessment.

While the SPSP VTE workstream strives to deliver, and demonstrate uptake of, standardised evidence-based patient VTE risk assessment and administration of appropriate thromboprophylaxis, there is no nationally agreed measure of its efficacy. The real clinical benefits of this programme should be a reduction in VTE events, especially VTE events associated with hospital admissions (i.e. HA-VTE).

V Flag:

Since 2014, our radiology colleagues have been 'flagging' imaging reports which are positive for DVT or PE. Although this may be an underestimate it generates an unbiased sample of objectively confirmed VTE events that can be further analysed to ascertain the rate of HA-VTE.

Between 2014 and 2016 the % HA-VTE (examined in 6-month blocks) identified through the radiology flagging system appears to have fallen steadily from 40% (consistent with our historical audit data) to around 20-25%.

This apparent improvement may well reflect the SPSP VTE workstream activity as well as generally greater awareness by healthcare staff of VTE risk and prevention in hospitals.

Adverse events and significant clinical incident investigation

The VTE Safety group, a subgroup of the NHSGGC Thrombosis Committee, meets quarterly to discuss clinical incidents reported via DATIX pertaining to anticoagulant medications. Nine significant incidents were investigated during 2016, including 4 SCIs.

One incident involved dispensing the incorrect strength of warfarin (5mg instead of 0.5mg) in the community resulting in the patient's admission to hospital. Many new safety procedures have been put in place in the pharmacy involved but Glasgow and Clyde Anticoagulation Service are also reviewing their role in avoiding the need for the prescription of 0.5mg tablets.

Other incidents have led to the further safety work. An NHSGGC policy on risk assessment and administration of thromboprophylaxis for patients with casts in Emergency Department and subsequent fracture out-patient clinics. Collaboration between orthopaedics and Emergency Department colleagues is establishing new policy recommending VTE risk assessment for particular types of lower limb injury requiring immobilisation and administration of pharmacological thromboprophylaxis in those patients with specific additional risk factors.

Education

Education of healthcare staff is essential if the many VTE related guidelines and policies are to be implemented and followed. Indeed, as mentioned above review of anticoagulant medication incidents identified lack of knowledge and understanding in relation to anticoagulant prescribing as a recurring problem. Thrombosis Committee members are therefore active in delivering appropriate education at undergraduate and postgraduate level. A common educational slide set is being developed for delivery of education on VTE and anticoagulation to FY doctors across NHSGGC.

Since 2013 NHSGGC have hosted a Thrombosis Evening as part of National Thrombosis Week or World Thrombosis Day. The 2016 event was held on the 4th Oct at the GRI
Eight speakers covered the following topics, including:

1. Management of Upper Limb DVT
2. Management of Incidental VTE
3. Management of Antenatal VTE, Prevention and Treatment
4. Outpatient Management of Pulmonary Embolism

Future activities and challenges for 2017

The main focus for the NHSGGC Thrombosis Committee during 2017 will be directed towards:

- facilitating and supporting spread of the SPSP VTE workstream activities
- supporting ED and Orthopaedic colleagues develop a policy for risk assessment and thromboprophylaxis in out-patients with lower limb injuries
- support acute medicine colleagues refine and implement policies for ambulatory management of PE
- finalise HA-VTE audit tool and promote its use
- continue educational activities for GG&C healthcare staff
- establishing North, South and Clyde sector Thrombosis Groups to facilitate local implementation of VTE prevention and treatment policies