NHS Greater Glasgow & Clyde

NHSGGC Board 16 October 2018

Dr Jennifer L Armstrong, Medical Director

CLINICAL GOVERNANCE ANNUAL REPORT 2017/2018

Recommendation:-

The Board is asked to note the attached Clinical Governance Annual Report 2017/2018

Purpose of Paper:-

To update the Board on the achievements made within the Clinical Governance department to support the delivery of high quality clinical care to patients across NHSGG&C

Key Issues to be considered:-

None

Any Patient Safety /Patient Experience Issues:-

Examples of Patient Experience are described within the Annual Report.

Any Financial Implications from this Paper:-

No issues in the immediate term

Any Staffing Implications from this Paper:-

No issues in the immediate term

Any Equality Implications from this Paper:-

No issues in the immediate term

Any Health Inequalities Implications from this Paper:-

No issues in the immediate term

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

No.

Highlight the Corporate Plan priorities to which your paper relates:-

Better Care-

- Implement Excellence of Care across the acute wards and implement the process across all other patient areas.
- Ensure full implementation of the requirements and learning points from all external reviews.
Better Workplace

- Implement the Duty of Candour policy and establish appropriate reporting mechanisms within, and to, the NHS Board.

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Date – 16 October 2018
Clinical Governance Annual Report
2017-2018

Dr Jennifer L Armstrong
Medical Director
NHSGG&C
## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Front page</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Table of contents</td>
<td>2</td>
</tr>
<tr>
<td>1.</td>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>Clinical Governance Arrangements</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>Person-Centred Health and Care Programme</td>
<td>5</td>
</tr>
<tr>
<td>4.</td>
<td>Clinical Effectiveness</td>
<td>7</td>
</tr>
<tr>
<td>5.</td>
<td>Patient Safety and Clinical Risk Management</td>
<td>12</td>
</tr>
<tr>
<td>6.</td>
<td>Conclusions</td>
<td>16</td>
</tr>
<tr>
<td>Appendices</td>
<td>1: Real-time care experience improvement model</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>2: Statement of Assurance on Clinical and Care Governance Arrangements : 2017-2018</td>
<td>18</td>
</tr>
</tbody>
</table>
1. **Introduction**

The Health Act 1999 requires that every NHS Board in Scotland to:

"Put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals."

This statutory Duty of Quality applies to all services NHS Greater Glasgow and Clyde (NHSGG&C) provide in connection with the prevention, diagnosis or treatment of illness. It includes services that are jointly provided with other organisations. Essentially NHSGG&C must satisfy this duty of quality through internal arrangements and also through effective collaboration with partner organisations.

The framework of arrangements we put in place to meet this Duty of Quality, and all its associated activities, is referred to as **CLINICAL GOVERNANCE**.

1.1 Each year NHSGG&C 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: Person-Centred, Effective, and Safe Care. There is also a section reflecting on the arrangements for clinical governance through which we support and coordinate our actions whilst contributing to organisational assurance.

1.2 This report will describe the main governance framework and demonstrate our work to improve the quality of care in our Board. The report has been developed by the staff of the Clinical Governance Support Unit to present a small selection of the activities and interventions from across NHG G&C. There is substantially more activity we can be proud of, which arises from our shared commitment to provide a quality of care, than can be included here.

**NHSGG&C,** one of 14 territorial NHS Boards in Scotland, was formed in April 2006. It provides services to a core population of 1.1 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 around 38,000 staff who deliver services across its core area, as well as, providing specialist regional and national services to more than half of Scotland’s population. We are responsible for the provision and management of the whole range of health services in this area including hospitals and General Practice. NHSGG&C also works alongside partnership organisations including Local Authorities, the voluntary and independent sector.

2. **Clinical Governance Arrangements**

2.1 The NHS Board provides oversight and considers various reports on clinical quality at its meetings, which are provided by the Medical and Nurse Directors as the appointed Executive leads. The Clinical & Care Governance Committee(C&CGC) is a standing sub-committee of the NHS Board and provides a more intensive Non Executive oversight of clinical governance at its meetings.

2.2 The C&CGC maintains a process of agenda planning that ensures clinical quality and patient care experience are routinely monitored and reviewed. There are standard items and a range of topic specific reports on key developments and risks or broader aspects of clinical quality and governance. As an additional mechanism to support oversight and transparency the minutes of each meeting of the C&CGC are routinely reviewed by the NHS Board.

2.3 At the end of this year the Clinical & Care Governance Committee produced a statement of assurance confirming it had maintained its role in overseeing the clinical governance arrangements. A copy of the statement is included at appendix one of this report, which describes the membership and items reviewed during the year as part of its role.
2.4 One of the roles of the C&CGC is to oversee the work of the Board Clinical Governance Forum (BCGF). The BCGF provides more operational direction and underpins the Executive lead roles of the Board Medical Director and Board Nurse Director for person centred, effective and safe care. The Forum's main role is:

- To monitor Clinical Governance arrangements and ensure reporting lines to the C&CGC (NB the corporate clinical governance arrangements are described in figure one).
- To manage corporate aspects of the clinical governance policy and objectives
- To provide leadership, communication and support to NHS GG&C services in the effective and consistent application of clinical quality improvement and in the maintenance of local clinical governance arrangements.

The BCGF is the coordinating point of a larger set of multidisciplinary arrangements (described in the following diagram) which connect teams, departments and services in collectively monitoring and improving clinical quality.

Figure one: Corporate Level Clinical Governance Arrangements

Diagram of Corporate Level Clinical Governance Arrangements

Good Practice Example: The Clinical Governance Review Meetings

At every meeting of the Acute Services Division Clinical Governance Committee, the leads for clinical governance provide a written and verbal update on achievements, risks and objectives. Outside the meetings we have established a more in-depth clinical governance review process. The review provides for a more detailed assessment of key issues to identify how strategic leads can support services in meeting the duty of quality. The meetings are chaired by Dr Chris Deighan, the lead for clinical governance in the Acute Services Division, who describes his experience as follows.

"After an initial trial period, the Clinical Governance Review meetings have become an important and valued part of our arrangements. The meetings provide time to understand more fully how local leads and the senior team can work to resolve challenges and improve clinical quality. We have provided positive feedback and shared learning, as well as having the occasional honest conversation where a situation needs improved. It has been especially encouraging to see the role of the meetings in consolidating good practice across the Division."
3. Person-Centred Health and Care Programme

Care experience is a key component of how we define quality care and acknowledged as a priority in both the Scottish Government’s 2020 Vision\(^1\) and the Healthcare Quality Strategy for Scotland. Person-centred care describes mutually beneficial partnerships between patients, their families and those delivering health and care services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared-decision making.

3.1 This section of the report summarises the annual report of the Person-Centred Health and Care (PCHC) Team for 2017/18. There are numerous activities and improvement projects across NHS GG&C which aim to improve the experience of healthcare for patients. These are reported separately, along with details of the Board’s response to its statutory requirements to secure feedback from patients and monitor the use of this information in improving care. The report is available at the link: [http://www.nhsggc.org.uk/media/248952/nhsggc_annual_report_fccc_2017-2018.pdf](http://www.nhsggc.org.uk/media/248952/nhsggc_annual_report_fccc_2017-2018.pdf)

3.2 Summary of Key Achievements

Key achievements for the Person-Centred Health and Care Team are as follows:

- From April 2017 – March 2018, the team has conducted one thousand one hundred and sixty-four (1,164) in-depth care experience conversations. These conversations gather feedback from people using a structure of themes known to be important aspects of care. As a result of this, overall care experience has improved by 4% with specific individual themes improving by up to 13%.
- The clinical team in the Acute Assessment Unit at Glasgow Royal Infirmary contributed to the recording of a film with the Person-centred Care Team from Healthcare Improvement Scotland to highlight improvements taken forward in the unit. This is now publically available on the iHub website. Examples are included in Table 1 on Page 7.
- Two hundred and eleven staff attended a person-centred health and care awareness session within the acute sector from April 2017 – March 2018. This was an opportunity to discuss with staff how to adopt person centered principles into routine practice.

3.3 Key Learning

A number of key learning points have been identified over the year. These are shared across NHS GG&C as well as incorporated into the working processes of the PCHC programme team with clinical teams involved in using the “real-time” care experience improvement model (Appendix 1). In this approach patients are interviewed whilst receiving care so their experiences are current and can be used to make immediate real-time improvements. The key learning is as follows:

- Feedback from people in care is effective in helping clinical staff to relate and identify more specifically the choices and preferences which are important to people in their care.
- Helping staff to apply the person-centred principles into their clinical practice creates more positive interactions and behaviours with patients.
- Staff are able to apply feedback in constructive and creative ways to improve patient experience.
- Patients and relatives also offer improvement ideas and solutions within the feedback conversations.
- Care experience feedback can help to identify gaps in staff training and development.
- The involvement of senior managers in the improvement discussions can be helpful to the clinical teams, particularly in removing barriers to progress.
- Sharing the feedback with other services linked to the clinical areas i.e. pharmacy, radiology, facilities etc. helps to create opportunities for multi-disciplinary improvements to occur for the benefit of a larger patient group.
3.4 Person-Centred Care Awareness Sessions for Staff

During discussion in the staff awareness session, staff are asked ‘what person-centred care means to them?’ and ‘what core skills, values, attitudes and behaviours are required to provide good quality person-centred care?’ Staff responses to these two enquires can reinforce the positive, meaningful aspects of person-centred care and are illustrated in the next two figures.

Figure 2: Staff responses – ‘What does person-centred care mean to you?’

![Image 1](image1)

Figure 3: Staff responses - ‘What core skills, values, attitudes and behaviours are required to provide good quality person-centred care?’

![Image 2](image2)
Some examples of comments received from staff help to illustrate the value they get from their involvement in the ‘real-time’ care experience improvement model.

‘Reading what patients have said gives us confidence in how we provide our care and we try to provide the best person-centred care possible while still learning.’ (Staff member, ward 67, Queen Elizabeth University Hospital)

‘It’s good knowing you’re doing things right as well as being aware that some things need to change and seeing why it needs to change from a team discussion to support us all.’ (Staff member, K North, Inverclyde Royal Hospital)

‘If things are always reported as good there’s nowhere to go, so getting feedback lets us reflect as a team and individually to make sure we offer the best care we can.’ (Staff member, Physically Disabled Rehabilitation Unit (PDRU), Queen Elizabeth University Hospital)

‘The feedback feels real and honest and I’m glad to address and improve things.’ (Staff member, ward 10, Royal Alexandra Hospital)

3.5 Key Objectives Planned for 2018 – 2019

The following objectives are agreed for the PCHC programme team for April 2018 – March 2019:

1. Integrate the programme with ‘Excellence in Care’ (the national Nursing approach to care quality) within NHS Greater Glasgow and Clyde.
2. Extend implementation of the medical pathway ‘real-time’ care experience programme at Glasgow Royal Infirmary to develop leadership behaviours that enable person-centred care improvement.
3. Explore and secure development opportunities to include the following:
   a. Share learning of qualitative analysis techniques.
   b. Seek opportunities for external funding and submit funding bids to support person-centred care development.
   c. Produce learning summaries, case study reports, poster and oral presentations and publications to document and share learning of person-centred care quality improvement achievements using the ‘real-time care experience improvement model.’

Table 1: Good Practice Example: Real Time Care Experience

The ‘real-time’ care experience feedback has been gathered across the medical pathway of care to gain a greater insight and understanding of the whole system care experience. Care Experience feedback has been gathered and developed through a face-to-face conversation with patients and their relatives/carers. Improvements are identified and actioned from feedback. Some examples include:

<table>
<thead>
<tr>
<th>AAU</th>
<th>AAU has improved their waiting areas for patients and relatives. An “open door” policy to allow family members to support their relatives.</th>
</tr>
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<tbody>
<tr>
<td>MRU</td>
<td>Nursing and clerical staff are working to improve communication to ensure patients and their Next of Kin are informed of transfer details to downstream wards.</td>
</tr>
<tr>
<td>Ward 4</td>
<td>Volunteers in ward 4, GRI provide stimulation and support for people with cognitive impairment and social interaction for people with no visitors. Nursing Staff are working with volunteers who visit the ward to provide support and stimulation for patients to alleviate distress and isolation where possible.</td>
</tr>
<tr>
<td>HDU</td>
<td>HDU, GRI have implemented the ‘Getting to Know Me’ Document to ensure the needs, choices and preferences of people with cognitive impairment, communication impairment or learning needs are acknowledged and that care is focused on ‘what matters’. Good examples of use of what matters to me boards with patients and families</td>
</tr>
</tbody>
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4. **Clinical Effectiveness**

This section of the report summarises the annual report of the Clinical Effectiveness Team for 2017/18.

4.1 **Key achievements**

Key achievements for the year are outlined below:

- **Quality Improvement Project Support** - 82 local improvement projects have been supported during 2017-2018

- **Scottish Patient Safety Programme (SPSP)** - The team has provided coaching, data analysis, and programme management to SPSP Acute Adult, Mental Health, Primary Care and Maternity & Children Quality Improvement Collaborative.

- **QI Capability** - The Clinical Quality Improvement Network (CQIN) has been developed to learn and enhance applied Quality Improvement practice across NHSGGC, to learn about effective network behaviours and use these to develop CQIN further. A twitter account has been progressed to promote the network. A survey has been undertaken to engage with those individuals who have undertaken a national quality improvement development programme to engage them in local activities that will build and develop the network further.

A range of QI training has also been delivered to improve awareness and understanding of quality improvement principles and methodology:

  - Full day QI workshops have been delivered to 253 staff this year (13 workshops)
  - 6½ day QI awareness sessions have been delivered to 138 staff over 6 sessions
  - QI input to the ‘Making a Difference’ Programme, which has now trained 400 Band 5 nurses, and 19 Band 6 midwives.

Staff who had undertaken the full day training were also offered a coaching relationship to help establish local QI projects, putting into practice the skills taught on the course.

- **Quality Improvement Support Framework** – A Support Framework has been developed to describe the different types of support provided by the team, to ensure that this is provided consistently and effectively. This will be evaluated within the team over the next few months

- **Clinical Guidelines** - There has been over 3000 hits to the Clinical Guideline Directory home page each month, with an average of 100 hits from 80 distinct users. An updated Clinical Guideline Framework has also been launched. There are currently 506 clinical guidelines posted on the Clinical Guideline Directory with 96% current and valid.

- **Clinical Governance Related Publications** - 87 Clinical Quality Publications have been identified for review since January 2014. The team now offer face to face support to reviewers to discuss content, assessment of service implications and consideration of actions. Standard reports in the form of an SBAR (situation, background, assessment, recommendation) communication tool are now provided to key governance groups to highlight findings. 35 national guidance publications from Scottish Intercollegiate Guidelines Network (SIGN), Healthcare Improvement Scotland (HIS) Standards and National Institute for Health and Care Excellence (NICE) have been identified and reviewed in 2018/19.

- **Liaison Support to Key Groups** - Each Directorate or Partnership (HSCP) has a clinical effectiveness liaison who works closely with the Clinical Governance lead. Standard reports have been prepared for governance groups and includes updates on Clinical Guidelines processes to track clinical quality publications and processes to impact assess national guidance and NICE IPGs.
4.2 Improvements to Care

During 2017-2018, 82 “Improvement to Care” projects were supported by the Clinical Effectiveness Team. We have highlighted 3 examples in this report to highlight the impact of these interventions on patient care.

**Improvements to Care 1: There's no place like home**

The project in ward 62 Glasgow Royal Infirmary is trying to help patients return home after shorter hospital stays following a primary joint replacement. They are doing this by ensuring a range of care interventions are more effectively applied. As part of this project the team have already improved hydration management and patients having a restful night.

There has been an increase in the number of completed fluid balance charts on the ward. Through the testing of 4 change ideas the data went from 15% to 100% over a period of 20 weeks.
Improvement to care 2: Reduction in Waiting Times for Minor Adaptations Equipment From Occupational Therapy

The aim of this project was to reduce the length of time that patients had to wait for minor adaptation equipment (e.g. handrails, door entry systems) to be installed in their homes.

The original process began with Health OT staff assessing a patient, if the patient required any modifications to their home, this had to be referred on to a Social Work OT. This led to delays in the referral process as well as a duplication of work. This project was piloted with one team in the North West HSCP for 12 weeks. When the new process was implemented, the average time from assessment to referral went from 12 days to 1 day. This meant that OT staff were able to start the patient’s rehabilitation much quicker. There has been a notable reduction in the length of time patients now have to wait between being assessed for equipment to having it installed in their homes. This also allows for the rehabilitation process for the patient to start sooner and staff are reporting this as a positive change.
Improvements to Care 3: Vulnerable Women’s Clinic

The project aim stated that by March 2018 service users attending the Opioid Replacement Treatment (ORT) New Women’s Clinic will have had 60% improved engagement with the clinic and will have 50% improvement in ORT Concordance.

The clinic cares for vulnerable women by offering trauma informed care in addition to the treatment and care for alcohol and drug issues. Low engagement with services is a particular challenge for this group of patients. The clinical team therefore aimed to improve engagement and concordance. The team is comprised of two gender based violence workers, an addictions nurse, a medical officer and a clinical psychologist. The weekly data collected for this QI project has demonstrated overall a clear correlation between patients seeing a member of clinic staff and an increase in safety work (part of trauma informed care). There are improved outcomes for the patients in terms of ORT doses being taken and the stability of ORT dose. Patients who have been with the service for many years have been able to provide drug free urine samples for the first time ever in some cases. The clinic team is pleased to report the sense of pride felt by those service users who have been with the service for many years and have been able to move on as a result of the trauma informed care which they have received.

4.3 Scottish Patient Safety Programme

Some of the key outcomes for the Scottish Patient Safety Programme are outlined below

- In the Acute Adult Deteriorating Patient programme, the spread of the work stream is monitored in two parts with 86% of teams reliable in monitoring the Frequency of Clinical Observations; and 72% of teams reliable in achieving a Structured Response to a early warning score requiring escalation(at May 2018).
  The Mental Health risk assessment bundle has increased to 86% with many of the wards submitting over 95% process reliability on a regular basis. To achieve success this workstream, the mental health risk assessment must be robust and comprehensive which is achieved by adherence to the Multidisciplinary T checklist.
- In Primary Care, the Disease Modifying Anti Rheumatic Drugs (DMARDs) workstream is designed to ensure the monitoring and follow up of patients taking this type of medication is appropriate to avoid the potential impact of side effects. Reliability with the DMARDs bundle elements has steadily increased over the 3 years from 36% to 82%. Engagement has also been steady and ranges from 56% to 89%.
- In the Paediatrics programme, work to reduce Ventilator Associated Pneumonias continues to show improvements with the number of days between VAP’s increasing from an average of 24 days in 2014 to an average of 123 days in 2017/2018.
- The Tissue Viability Nurse Specialist team has used the opportunity of SPSP implementation to contribute to the development of a revised risk assessment document,
Pressure Ulcer Daily Risk Assessment (PUDRA). This new tool includes all of the best practices advocated by the SPSP care bundle. PUDRA has been rolled out to all adult acute wards and has been adapted for paediatrics and neonates. Monitoring has established that 47% of wards (107 wards) have achieved 300 days or more pressure ulcer free.

4.4 Clinical Quality Improvement Network (CQIN)

Following a Clinical Governance Stakeholder Event focussing on Quality Improvement in December 2016, CQIN were commissioned to develop a Clinical Quality Improvement Strategy. Between February and May 2017 a search and synthesis was carried out to better understand the key enablers for improvement, what the key factors of a QI strategy or programme are and what do high performing organisations do. Using this information, the development of a quality focused driver diagram began in August 2017. The driver diagram has been presented at a selection of improvement groups and governance committees with revisions made following each discussion. Individuals and groups having been using the elements of the driver diagram to clarify what actions need to be developed to improve quality, to consider whether the existing projects are broad enough in scope and to confirm how the different strand of activity are complementing the overall aim of high quality clinical care.

4.5 Infrastructure Development

The Clinical Effectiveness Team has been working to produce and develop information for the services which will help them to understand and adopt a QI approach. Below are examples of the resources that have been developed throughout the year.

- How to Guides: These guides are designed to provide advice for those carrying out a quality improvement/audit project, giving information on when and how to use the tool/resource, as well as examples of use.
- Clinical Effectiveness StaffNet Pages where staff can access support and resources were redeveloped and the new pages were launched in March 2018

4.6 Data and Analytics

- The Clinical Effectiveness Team provides quarterly reports of Hospital Standardised Mortality Ratio (HSMR) figures. Where these figures are perceived to be unusually high for any Hospital Site, the Data team then initiates a more in depth review. This involves analysis of the case list, the organisation of casenote reviews and producing reports summarising the key findings. During this year, in response to higher than expected HSMR we have been working with Healthcare Improvement Scotland to understand the factors contributing to a relatively higher than expected HSMR at the Vale of Leven and Royal Alexandra Hospitals. There have been specific improvements in the quality of information supplied by these hospitals as well as additional assurance reviews (including Healthcare Improvement Scotland) to ensure that there are no significant concerns about the quality of care and development of the clinical quality improvement programmes at each hospital.

4.7 The Clinical Quality Measurement Project was commissioned by the Board Medical Director and there are three main aims. This purpose of the project is:

1. Development, implementation and evaluation of board level outcome focused data for corporate and public assurance.
2. Development, implementation and evaluation of sector/directorate/HSCP level outcome focused data for improvement and assurance.
3. Greater access to data for clinical teams, so information is practically applied in support of quality improvement and assurance.
Good Practice Example: Palliative Care - Discontinuing unnecessary interventions at end of life
The Palliative Care team carried out a quality improvement project 'Discontinuing Unnecessary Interventions at the End of Life'. It was noticed by a junior doctor that patients who were felt to be dying were managed with lots of active interventions, including blood tests and frequent monitoring of blood pressure, pulse, temperature etc, which were done without changing the management or outcome for these people. The project team were keen to show the benefits in shifting the focus of care for patients at the end of life away from invasive, futile procedures which do not enhance their care, towards focusing on their comfort and dignity at the end of their lives. In addition, it was felt that a collaborative piece of work between nursing and medical staff would serve to highlight the improvements that may be made to patient care when different disciplines work together with a shared common goal. Three wards in GRI and QEUH participated in the project to reduce the proportion of people having NEWS monitoring and unnecessary blood tests performed, within 24 hours of death, by 50%.

Good practice example: The Renfrewshire BNP pilot study
Providing access to the blood test Brain Natriuretic peptide (BNP) in primary care for the diagnosis of heart failure, is clinically and cost effective and improves the patient journey. 29 Renfrewshire GP practices (population 172,000) were provided with access to BNP in primary care in order to reduce referrals to the hospital based Heart Failure Diagnostic Pathway clinic (HFDP). HFDP waiting times were reduced for GP referral to echo from 19 weeks to 6 weeks and GP referral to cardiologist review from 19 weeks to 6 weeks. Patients with normal ECG and BNP in primary care were no longer required to attend the hospital clinic (50% reduction in referrals). The ‘Renfrewshire BNP Pilot Study’ results formed a successful business case and BNP testing in Primary Care in GGC was funded and initiated in December 2017.

5. Patient Safety & Clinical Risk Management

This section of the report summarises the annual report of the Patient Safety (and Clinical Risk Management team) for 2017/18.

5.1 Significant Clinical Incidents (SCI)

From April 2017 to March 2018, a total of 288 clinical incidents were escalated to SCI status which is an increase of 13 events from the previous year (Acute - 209, Partnership - 79).
There were two objectives for Clinical Risk in 2017/18 in relation to SCIs;

- To assist clinical services to provide evidence that changes made following an SCI has led to improvement
- To review the process of significant clinical incident reporting, investigation and management: to ensure clarity of steps, supporting tools available and no duplication in effort.

These have been met by the following actions:

- Guidance provided to service relating to the development of robust action plans.
- Clinical Risk encourage service to include actions from SCIs on service clinical governance work plans as necessary and taken forward through improvement projects where appropriate.
- Incident analysis provided to review whether there has been a reduction in incidents.
- Thematic analysis to review themes from significant clinical incidents provided.
- SCI Investigations are quality assured to ensure they are robust and where appropriate identify a root cause (why) in order for more specific recommendations to be generated.

5.3. Self Assessment following Ayrshire & Arran (A&A) Adverse Event Review

Following a Health Improvement Scotland (HIS) review of Adverse Events in Maternity Services in Ayrshire and Arran, the report from HIS produced a number of recommendations and other Boards in Scotland were invited to assess themselves against these to ensure compliance with the National Framework for Adverse Events. As GG&C did not have the same issues as were identified in Ayrshire & Arran, the review of these recommendations was performed by firstly identifying the strengths and weaknesses in the current arrangements followed by an action plan to address any shortfall. The themes of the recommendations were:

- Strengthen the process
- Improve family engagement
- Support for staff
- Promote shared learning
- Public visibility
- Improve staff training and education
- Identify clinical training requirements visible within Clinical Governance arrangements
- Implementation of the National Framework as well as external quality assurance under the Quality of Care approach.

Overall the GG&C policy framework and its application were considered robust however this opportunity was taken to improve the arrangements further. Examples include developing...
more thematic analysis reports, support leaflet for staff involved in an incident and developing letter templates to help the services communicate with patients and their relatives.

### 5.4 Thematic Analysis & Focus Groups

There was recognition that there would be organisational benefit in performing more thematic analysis of significant adverse events. Thematic analysis was carried out for the following:

**Consent Errors** - An analysis of common aspects of these cases helped to create understanding of the conditions which made these errors more likely. A workshop was developed with theatre nursing staff to confirm the theories gained from the analysis and a checklist of key requirements was proposed as an aide memoir when checking a consent form to ensure no element of the checking was missed and the check was robust.

**Suicide Reviews** – A set of questions was incorporated into the Datix system, and reports from this data were presented to the mental health governance executive group and revealed significant participating factors to suicide were employment, social isolation and relationships.

**Unseen Diagnostic Results** - A theme became apparent across different specialties and different sites that there was an issue with the ‘sign off’ of electronic patient investigation results. A short life working group was commissioned and plans put in place to make it easier for clinicians to ensure any investigations requested are reviewed and appropriate action taken. This included:

- Review of paper reports from laboratories
- Provision of a guide as to how to create work lists on TrakCare
- Changes to the TrakCare system to allow results lists to be customised by users to allow easier management

**Management of Patients with Diabetes** - The analysis revealed that there were knowledge gaps for general nursing and medical staff, confusing paperwork to complete and a failure to seek help from staff who specialise in Diabetes management at an early stage in the care plan. The analysis paper was reviewed by the Acute Clinical Governance Forum and also shared with the Inpatient Management of Diabetes Managed Clinical Network (MCN). The MCN then submitted a number of recommendations to the Operational Management Group for support and from this a short life working group has been established to start to address the recommendations.

**Medication Administration Errors** - An analysis paper was written to explain the issues expressed by the staff that contribute to error and breach of policy. The paper was shared with Chief Nurses and local action is taking place in response to the recommendations. The paper is also planned for discussion at a forthcoming Director of Nursing meeting to discuss some strategic direction relating to some of the issues raised.

### 5.5 Duty of Candour

Clinical Risk has been instrumental in supporting the implementation of Duty of Candour legislation in NHSGG&C and has also supported National work through working groups, committees and learning events. The new Duty of Candour policy contains guidance to assist staff to comply with the legislative framework. There is also a Duty of Candour page on StaffNet which contains additional information and links to training opportunities including a LearnPro module and face to face disclosure training. There have been additional codes added to the Datix system to allow an annual report to be created for Duty of Candour events. The compliance with Duty of Candour will be monitored via the Clinical Risk reports that are submitted to the Acute & Partnership Clinical Governance Forums.
5.6 Avoiding Serious Adverse Events Monitoring (ASEM)

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.

The majority of these cases (31) occurred in the Acute Division with the other 4 occurring in the Partnership areas. All of these incidents have been investigated as SCIs. This is an increase of 8 events from the previous year.

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Count</th>
</tr>
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<tbody>
<tr>
<td>Air Embolism</td>
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<td>Death or serious harm related to the use/ function of a</td>
<td>5</td>
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<tr>
<td>device</td>
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<tr>
<td>In Patient Suicide</td>
<td>1</td>
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<tr>
<td>Local anaesthetic performed on wrong body part</td>
<td>3</td>
</tr>
<tr>
<td>Medication error</td>
<td>14</td>
</tr>
<tr>
<td>NG Tube Misplacement</td>
<td>1</td>
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<td>Retained Item</td>
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</tr>
<tr>
<td>Serious blood transfusion incident</td>
<td>1</td>
</tr>
<tr>
<td>Surgery performed on wrong body part</td>
<td>4</td>
</tr>
<tr>
<td>Surgery performed on wrong patient/ wrong surgical</td>
<td>1</td>
</tr>
<tr>
<td>procedure</td>
<td></td>
</tr>
<tr>
<td>Wrong implant</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>

The surgery on wrong body part cases included 2 cases involving teeth, 1 oral-maxillofacial case where the wrong screw was removed and a urological stent that was inserted into the wrong ureter.

The retained items were both swabs and the error was discovered before the patient had left the theatre department but the wound had been closed. The swab was removed quickly with an additional procedure. These cases highlighted the need for compliance with the Accountable Items Policy regarding final swab checks.

5.7 Training and Education for Patient Safety

Education and training continue to be a significant component of the activity in Clinical Risk. In this past year, several sessions have been delivered on the following topics:

- SCI investigation, Root Cause Analysis and Human Factors
- Human Factors in Healthcare (Making a Difference Program)
- Human Factors for Quality Improvement (Quality Improvement 1 day program)
- Duty of Candour Disclosure training
- Duty of Candour update sessions
- Deteriorating patient and Sepsis
- Effective Morbidity & Mortality Meetings

There has also been opportunity to promote the work of the Board at National events on Duty of Candour, Adverse Events and Morbidity and Mortality.

5.8 Morbidity & Mortality (M&M) Improvement Project
A morbidity and mortality meeting provides an opportunity for clinicians to review the quality of care provided in an open forum with peers and colleagues by examining recent case studies. These may be complex cases that have been well managed, complications, adverse events or an unexpected deterioration or patient death. The aim of this project was to:
- Establish Morbidity and Mortality groups where there were none and
- Ensure all attendees feel the value of these groups in addition to achieving the agreed key elements.

There is now a Morbidity and Mortality page on StaffNet which contains some resources, and a toolkit which includes key documents. Clinical teams have found the improvement project and review process particularly helpful especially in light of Duty of Candour as it helped them to establish the difference between Significant Clinical Incidents and morbidity and mortality cases.

**Good Practice Example: Weekend Electronic Doctors Handover**

Within the 1st Deanery visit to Medicine Services at the QEUH, there was concern raised over handovers. We recognised this as an area to prioritise and our Chief Residents, clinical and management teams worked closely with our e-health team to develop an electronic handover structure. The electronic handover is based around standard questions laid out in Royal College of Physicians guidance but in addition also incorporates the important ‘aims and limitations of treatment’

We have now successfully developed an electronic medical handover embedded within the TrakCare platform that has now been adopted across NHS GGC. We already use an electronic SBAR for nursing handovers when patients move between wards. This work was nominated for the ‘Holyrood IT Awards’ as well as being presented at the ‘Big Brag’ Scottish Government event May 2018.

**Good practice example: Wrong-site surgery risk reduction in Plastics and Burns**

Plastics and Burns have undertaken work to reduce the risk of wrong site surgery. This includes the following improvements, which have now been embedded:

- Multiple cross-checking points instituted to reduce risk of wrong site surgery.
- New system of adding patients to waiting list to reduce errors on OPERA theatre booking system now embedded.
- New protocol instituted via West of Scotland Skin Cancer MCN relating to identification of correct sire for inter-specialty referrals.
- New consent process/check-list for out-patient LA patients

**6: Conclusion**

The Clinical Governance arrangements within the Board remain robust. The Clinical & Care Governance Committee has maintained effective NonExecutive oversight of the key areas of clinical risk and quality. The internal arrangements are well connected allowing engagement and exchange of information to ensure we are appropriately monitoring and improving the quality of clinical care.

In the next year we will continue to support quality improvement projects and maintain oversight of the quality of care. Our commitment to continuously improve means that we are constantly seeking to learn and apply new methods and approaches.

There are three primary areas we intend to develop for the clinical governance arrangements in 2018/19. Firstly, to contribute to the implementation of the clinical informatics strategy and ensure our clinical teams have easy access to data that can help them ensure high quality of care for patients. Our second aim is to develop the way in which we improve clinical quality, by building a knowledge of methods linked to the HIS Quality model to create larger scale, sustainable improvement.
programmes. Our final area is to evolve the clinical governance arrangements to support the Board’s Healthcare Quality Strategy.

Appendix One

Real-time care experience improvement model

The purpose of gathering feedback in this way is to find out what matters to people whilst receiving care. Feedback is gathered over consecutive monthly cycles using a semi-structured conversational approach referred to as a ‘themed conversation’ to develop a qualitative narrative of their experience, specifically with a focus on person-centred principles of care giving and interactions. The only exclusion criteria are people who are too acutely unwell to participate in conversations and those people with severe cognitive impairment. Where possible an invitation is extended to relatives and carers to provide feedback in these two instances to gain their insights into the quality of care and experience perceived from their perspective.
Appendix Two:

**STATEMENT OF ASSURANCE ON CLINICAL AND CARE GOVERNANCE ARRANGEMENTS: 2017/18**

The Clinical and Care Governance Committee met regularly in the last reporting period to review Clinical and Care Governance systems and improvement plans. Its membership was adjusted during the year involved:

Mrs Susan Brimelow OBE (Chair)
Mr Ian Ritchie (Vice Chair)
Mr Alan Cowan
Dame Professor Anna Dominiczak
Mr Ian Fraser
Dr Donald Lyons
Cllr Jonathan McColl
Mrs Dorothy McErlean
Mrs Audrey Thompson

The Chief Executive, Directors and Senior Officers attend meetings of the Clinical and Care Governance Committee as required. The minutes of the Clinical and Care Governance Committee meetings are shared and reviewed by the NHS Board at their regular meetings and then published on the website as part of the Board papers. The Clinical and Care Governance Committee has monitored clinical governance arrangements and developments and will approve the annual Clinical and Care Governance Report for 2017/18.

Standing items discussed at each meeting were:

- Report and review on significant adverse events and any associated Fatal Accident Inquiry relating to clinical services and patient safety from the Board Medical Director at every meeting.
- Direct updates from major service areas structured through a rolling programme of reports and presentations.
- Reports on progress and learning from the Scottish Patient Safety Programme at every meeting.
- Reports on Healthcare Associated Infection Control and performance indicators at every meeting.
- Reports on Healthcare Environment Inspections and action plans at every meeting.
- Reports on Hospital Standardised Mortality Rates at every meeting.
- Report from Board Clinical Governance Forum at every meeting.

A range of quality related items were also selected as issues became prominent with such items discussed at individual meetings including:

- Clinical Governance Strategy and Framework
- Clinical Governance Annual Report
- Clinical Effectiveness
- Healthcare Quality and Clinical Governance Strategy
- Prison Healthcare
- Relocation of services of Paediatric Ward 15 at Royal Alexandra Hospital to Royal Hospital for Children
- Moving Forward Together Programme
- Review of GG&C data on still births
- Putting Patients First - Implementation of the Patients Rights Act
- Unscheduled Care Review
- Duty of Candour
- Review of Maternity Services in NHS Ayrshire and Arran
- Child Protection Governance
Board Official

- Corporate Risk Register
- Review of Clinical Governance Committee Remit
- Paediatric Cardiac Services
- Clinical Governance SPSP Internal Audit (PwC)

Based on its review of this work, the Clinical and Care Governance Committee has concluded that, in respect of the year ended 31st March 2018, it has properly discharged its responsibilities and there was a satisfactory system in place during the year to provide reasonable assurance of the effectiveness of the arrangements for clinical and care governance.

Mrs Susan Brimelow OBE  
Chair of the Clinical and Care Governance Committee

Dr Jennifer Armstrong  
Medical Director