Clinical Governance Annual Report 2012-2013

1. Introduction

As Medical Director and as the Executive lead for clinical governance I take great pleasure in providing this annual report reviewing clinical governance in NHS Greater Glasgow and Clyde (NHS GG&C) covering the year up to the end March 2013. The purpose of this report is to share with staff and the public the work which takes place on a daily basis to continually improve the quality and safety of the clinical care. Patients and their families are at the forefront of everything we do. We are developing improved ways of using patient feedback to directly influence how we provide care to patients. We are reviewing our clinical incident process to ensure that we learn when things go wrong and implement changes to ensure we continually improve clinical care. Our clinical teams are at the forefront of implementing the Scottish Patient Safety programme and using up to date, evidence based guidelines to deliver modern, safe care.

During the year the Quality and Performance Committee supported the Board in recognising the continuous improvement of the Boards clinical governance approach and in particular the commitment of the many staff improving the safety and quality of care to patients, evident in the presentations and reports which were reviewed this year. The Committee concluded there was a satisfactory system in place during the year and that they had received reasonable assurance of the effectiveness of the arrangements for clinical governance.

Dr Jennifer Armstrong, Medical Director

1.1. NHS Greater Glasgow and Clyde (NHSGG&C) was formed in April 2006 to be the largest of the Health Boards in Scotland. It covers an area of 452 square miles in west central Scotland, providing services to a core population of 1.2 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. NHSGG&C annual budget is £2.8 billion funding the delivery of services in 25 major hospitals, 10 specialist units and 60 health centres and clinics. Its 44,000 staff deliver services across its home area, as well as regionally and nationally, providing specialist regional services to more than half of Scotland's population.

1.2. The intention behind this report is to describe the main governance framework and to share a small selection of the activities and intervention that aim to improve the quality of care in our Board. There is substantially more activity at personal, team, and service level arsing 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.

2. Clinical Governance Arrangements

2.1. During this reporting period (March 2012 to April 2013) the governance of clinical quality has been overseen by the NHSGG&C Quality & Performance Committee (Q&P). The Q&P Committee takes an overview of clinical governance and, on behalf of the Board, seeks assurance that clinical governance arrangements are working effectively to safeguard patients and improve the quality of clinical care.

2.2. In summarising its role each year the NHSGG&C Q&P Committee produces a statement of assurance on clinical governance arrangements, as part of the Statement on Internal Control required by the Scottish Government Health Directorate (SGHD). An extract of the statement is included at appendix one of this report, which describes the membership and items routinely reviewed during the year as part of its role. As a checking mechanism the minutes of each meeting of the NHSGG&C Q&P Committee were routinely reviewed by the full NHS Board.

2.3. It remains the case that there has been no new provision of guidance from Scottish Government Health Department or publication of clinical governance standards by Healthcare Improvement Scotland (HIS) in this period. In the absence of nationally published requirements or independent review from HIS, NHSGG&C have relied primarily on internal overviews of arrangements. NHSGG&C do supplement the analysis with input from audit processes, and Audit Scotland attend each meeting of the Q&P Committee.

2.4. There is one area of ongoing development notable during this period. The Board Clinical Governance Forum was reviewed and revised to strengthen its assurance functions in support of the oversight role of the Quality and Performance Committee. There is ongoing work to develop its working practice and ensuring it is fully meeting expectations will form an objective for the forthcoming year.

2.5. Each of the main services, (e.g. Acute Directorates and Community Health Partnerships) continues to maintain their own local arrangements, using specific clinical governance plans to confirm their focus on priorities for improvement. At the end of each calendar year there is reflection on the plans and activities of reporting and sharing, with many services running events such as clinical governance symposiums to share knowledge of good practice across services.

3. Person Centred Care

3.1. Last year we emphasised the focus on person centred care as part of the refreshed Board Clinical Governance Strategy. This year we have seen the launch of National Person-Centred Health and Care Collaborative in November 2012 as a key strategic priority for NHS Scotland. The programme seeks to challenge all parts of the health and care systems to put the person at the centre of services as well as delivering a person-centred collaborative, to reliably implement changes and interventions at all levels and across primary, community and acute settings. The collaborative is designed to help support people to close the gap between what we know we should do (the evidence) and what we actually do in practice.

3.2. The aim of the programme is that, by 2015, health and care services are more person-centred as demonstrated by improvements in three work streams; care experience; staff experience and in coproduction underpinned by leadership at an individual, team and organisational level. The design and establishment of the programme has been underpinned by quality improvement science, methodologies, approaches and expertise that aligns with the aims and ambitions of the NHS Scotland Quality Strategy and which NHS Staff have become familiar with through the learning collaborative improvement methodology used successfully by the Scottish Patient Safety Programme (SPSP).

3.3. The Executive leadership for the programme is provided by Rosslyn Crocket, Board Nurse Director, supported by the Head of Clinical Governance as lead for the programme implementation. We had

a large number of staff attending the launch event, drawing on the experience of other agencies and contributing to national learning. A number of teams have been identified to be the initial key pilot sites who will be testing and reliably implementing interventions and changes that are known to enable health and care services and organisations truly person-centred.

4. Patient Safety (& Clinical Risk Management)

4.1. It is the experience of all healthcare systems across the world that patients will occasionally suffer harm whilst being cared for. NHSGG&C 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 injury to patients, then by applying this learning, seek to improve levels of patient safety and well-being. Another part of our approach is through patient safety programmes, both nationally and locally set, which seek to create more reliable care processes and minimise risks.

4.2. 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 NHSGG&C. 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.

4.3. We actively encourage our staff to report all patient safety incidents through our reporting systems. 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. All of those events with the greatest learning potential are defined as Significant Clinical Incidents an subject to an investigative review to identify the potential for improvement to systems of care. The Board augments the arrangements to encourage staff reporting with a policy scheme of mandatory reporting of certain conditions or events. These events are then subjected to further investigation using the principles of root cause analysis.

4.4. The following charts provide an outline of our experience in investigating Significant Clinical Incidents. 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.
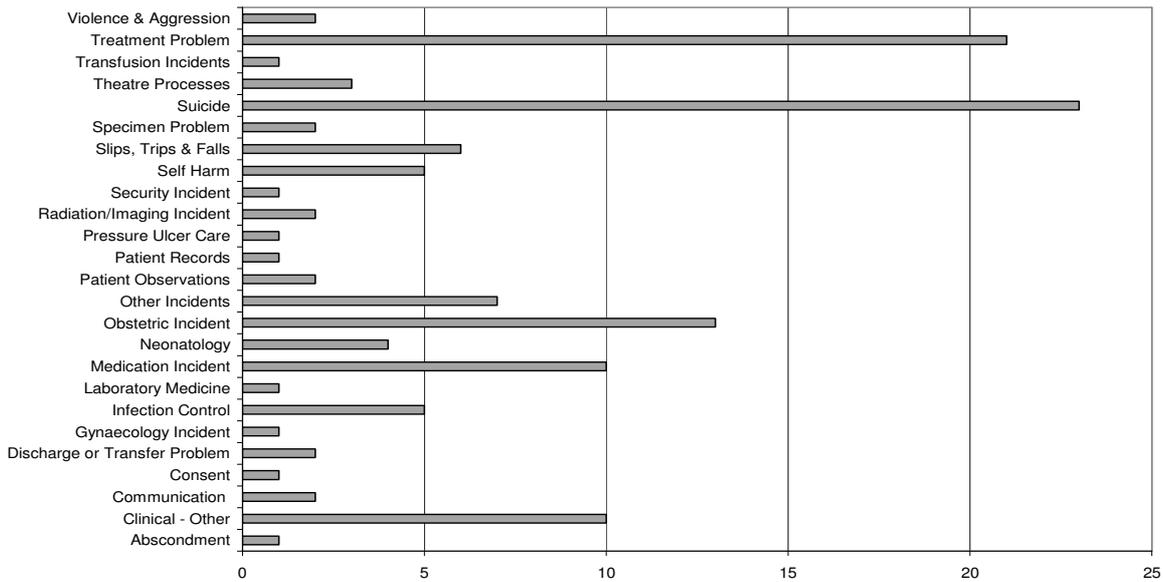
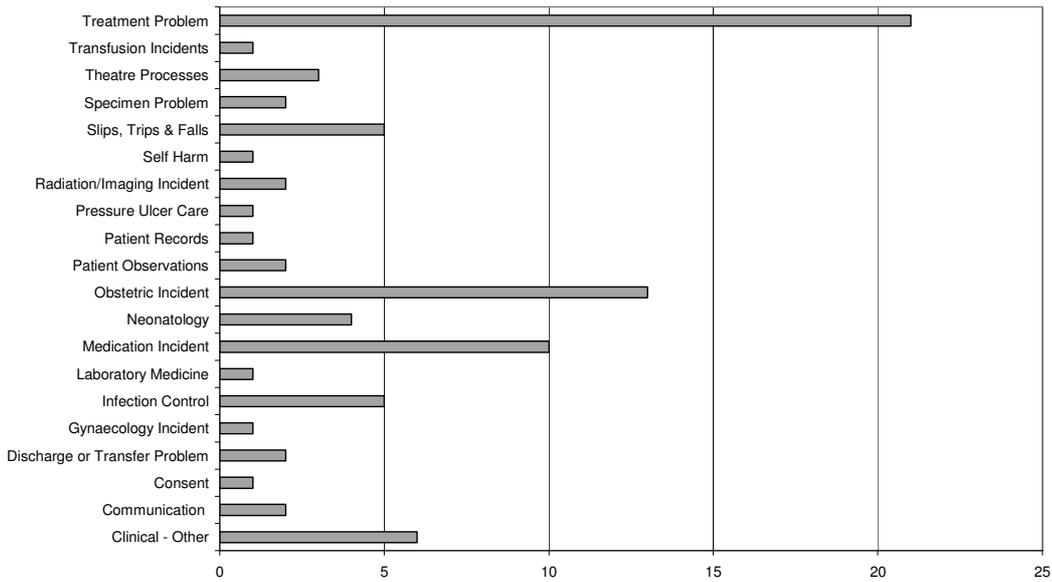**NHSGGC Significant Clinical Incidents April 2009 - March 2013**
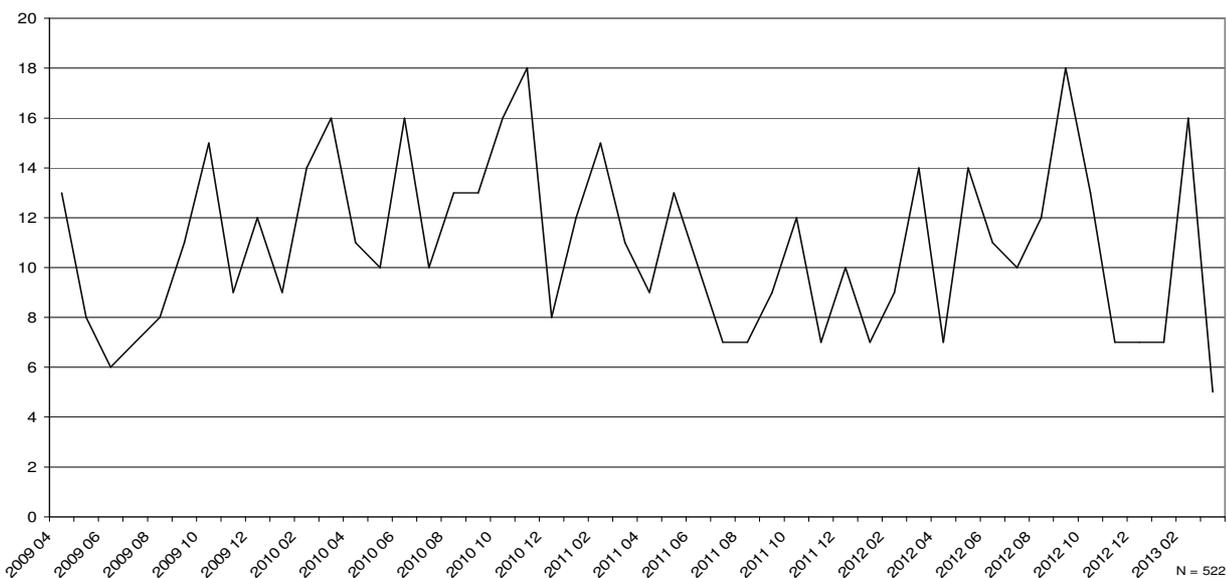
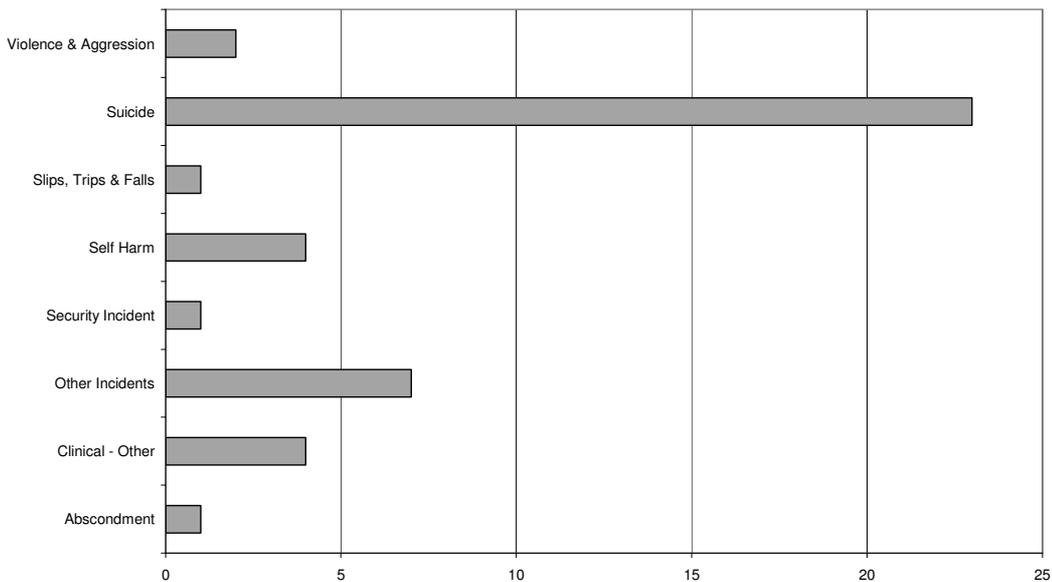**NHSGGC Significant Clinical Incidents April 12 - March 13**

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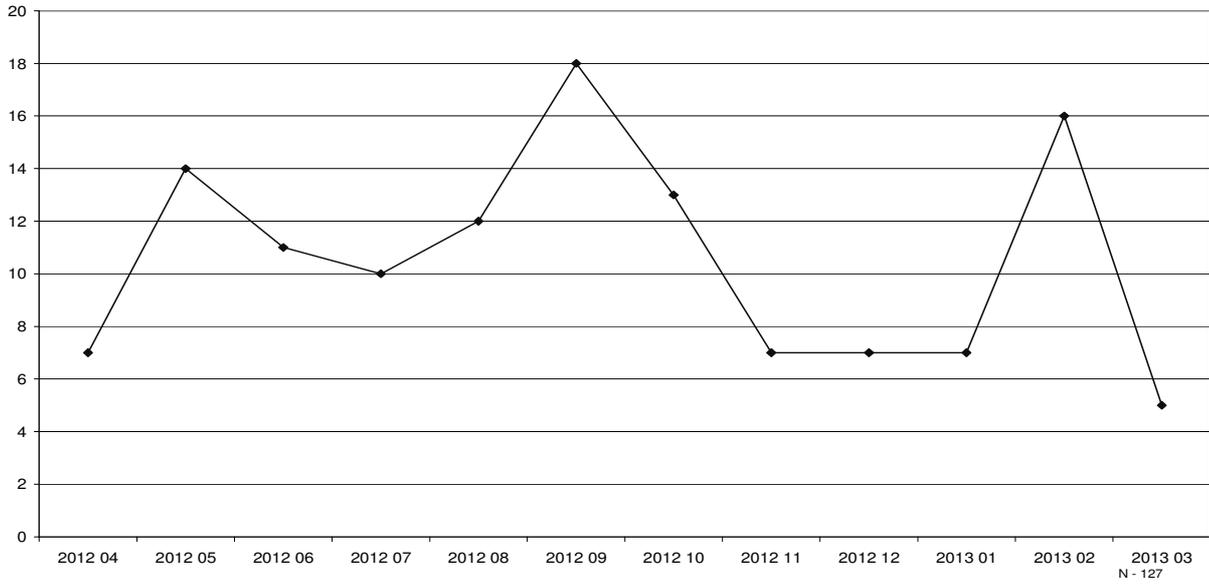
NHSGGC Significant Incdents by Category April 2012 - March 2013

NHSGGC Acute Services Significant Incidents by Category

Category	Value
Treatment Problem	21
Transfusion Incidents	2
Theatre Processes	4
Specimen Problem	3
Slips, Trips & Falls	5
Self Harm	2
Radiation/Imaging Incident	3
Pressure Ulcer Care	2
Patient Records	2
Patient Observations	3
Obstetric Incident	13
Neonatology	4
Medication Incident	10
Laboratory Medicine	2
Infection Control	5
Gynaecology Incident	2
Discharge or Transfer Problem	3
Consent	2
Communication	3
Clinical - Other	6

NHSGGC Partnerships Significant Incidents Apr12 - Mar13

Category	Value
Violence & Aggression	2
Suicide	23
Slips, Trips & Falls	1
Self Harm	4
Security Incident	1
Other Incidents	7
Clinical - Other	4
Abscondment	1

4.5. The NHSGG&C Clinical Governance Support Unit (CGSU) provides specialist support dedicated to the improvement of clinical risk. In sustaining and developing the overall clinical risk management system this year our major focus has been on reviewing the arrangements for the management of Significant Clinical Incidents. This involved direct engagement with a large number of key internal and external stakeholders. The publication of a new Board policy document has been delayed to take the fullest account of an ongoing a national review. We have however we started to upgrade the supporting framework of guidance to develop related risk practices. The review undertaken as part of our organisational analysis of existing practice identified that much of the development work

will be embedded in the supporting guidance and implementation of the policy and therefore we have identified additions to the guidance/toolkit that are currently under development as follows:

- Guidance for staff – "what to expect if I'm involved in an SCI"
- Guidance for managers – "supporting staff through an SCI"
- Recommendations – guidance on the develop recommendations from reviews
- Templates to support patient/ relative communication
- Information for patients/ relatives on process and what to expect
- Reflective practice account templates/ tips

4.6. Of course the key aim of clinical risk management is to improve the safety in care we provide as seen in the following examples:

Lead Directorate	Improvements made
Pharmacy and Prescribing Support Unit	**Safe Use of Antimicrobials**: - A programme of work to lead and support rational prescribing of antimicrobials continues to make a valuable contribution to the reduction of HAIs, notably C. difficile - Improved risk management practices to prevent harm associated with the increased use of gentamicin e.g. implementation of a standardised Gentamicin prescription chart which also supports administration and monitoring, Patient Information Leaflet. **Clinical Communication** Implementation of 'Prescribing Bites' programme which delivers key topical messages on medicines, face to face, to clinical pharmacy teams on all hospital sites every 2 months. Pharmacists are encouraged to further disseminate these messages within their multidisciplinary clinical teams.
Rehabilitation and Assessment Directorate	**Falls Reduction** Reduction in falls incidence compared to 2011 and reversed trend for last 2 years. In line with this the number of injuries such as fractures reduced. Two cycles of falls audits were undertaken across all RAD wards April and September 2012. The objectives were to measure compliance with falls risk assessment and falls prevention care plan for all inpatients with stays of greater than 23 hours and ensuring falls prevention interventions which promote safety in the patient environment were implemented. Quarterly action plans were implemented and significant improvements have been demonstrated with more than 80% of wards now sustaining 100% compliance with Falls Risk Assessments and Care planning.
Diagnostics Directorate	**Interventional Radiology** Realising the need for informed consent for patients undergoing planned Interventional Radiology procedures a risk rating system has been established for procedures which predicts the level of information and the setting in which that information is delivered. So for example for some procedures clinics have been established to allow patient's and their relatives to discuss the procedure in advance of their admission giving time and appropriate expertise to answer any questions. Other procedures require an information leaflet given before the procedure.
Mental Health Services	**Addictions** Examples of learning from incidents resulting in action to improve services in the last year include:

Lead Directorate	Improvements made
	• Review of processes for transfer of clients between Community Addiction Teams to avoid delay in client appointment. • Review of shared care to agree decisions about whether substitute prescribing should be by GP or medical officer for clients on an individual basis. • Ongoing review of supervised dispensing arrangements (including Pharmacy visits by senior staff) immediately following any medication – related incidents (such as any case of "double dosing") • Review of the implementation of training and practice in relation to "near misses" and the use of Naloxone therapy, further informed by specific incidents. • Selective and local implementation of improved risk analysis and safety responses in some waiting rooms and treatment areas (e.g. CCTV, limit to numbers, staff accompaniment). Generalisation (and transferability) of these lessons (and actions) is being reviewed currently. • Dissemination of best practice within addictions, acute and mental health services in relation to opiate substitution prescribing for inpatients.
Learning Disability Services	**Improving practice in relation to swallowing difficulties.** Difficulty in swallowing ('dysphagia') is a serious problem for some adults with learning disabilities and, in serious instances, can lead to death. Speech and Language therapists within the service have taken the lead on developing a Dysphagia Care Pathway, with the aim of improving practice around supporting people with swallowing problems and improving the management of risk. The pathway is informed by national safety guidance and is supported by standardized: assessment paperwork, review paperwork and a clearly defined risk assessment and management process. The pathway has now been rolled out to Speech and Language therapist within the LD service.
Acute Services Division	Work concluded this year to establish a clear pathway for the checking of Naso-gastric tube placement to be used for feeding. This Boardwide multidisciplinary initiative resulted in a new Naso-gastric Care Plan, advisory posters and advice leaflets for Nurses, Medical staff, Radiographers and Radiologists. This work was implemented in response to local incidents and a national recognition that standards of good practice require to be implemented to reduce recurrence.
Women & Childrens Directorate	Brief examples of improvements as a result of patient safety work in the Directorate include • Obstetric services have implemented the surgical briefing process for all patients requiring transfer to theatre to improve communication • Following an incident the investigation identified a need to improve the reliability of physiological monitoring with the local team changing documentation to address this and are now demonstrating reliable use of the CEWS for all patients in this area • Changes have been made to the level of observation required for children undergoing sleep studies in response to a near miss incident involving an entrapment issue • Neonates have developed standard guidance for the management of arterial lines which is being implemented across all units in response to

Lead Directorate	Improvements made
	issues identified through an SCI review

4.7. Another major safety aim has been associated with the Boards implementation of the Scottish Patient Safety Programme. Some landmarks from this year include:

4.7.1. As a result of a collaborative effort by clinical teams, leaders and support staff in Acute Services Division we observed a significant rise in the number of teams achieving reliable clinical processes in the General Ward workstream. For instance we observed excellent progress spreading reliable process use of the Early Warning Scoring System in clinical teams (target is 165 teams).see chart below.

GG&C Early Warning Scoring System Measurement & Reliability Achieved
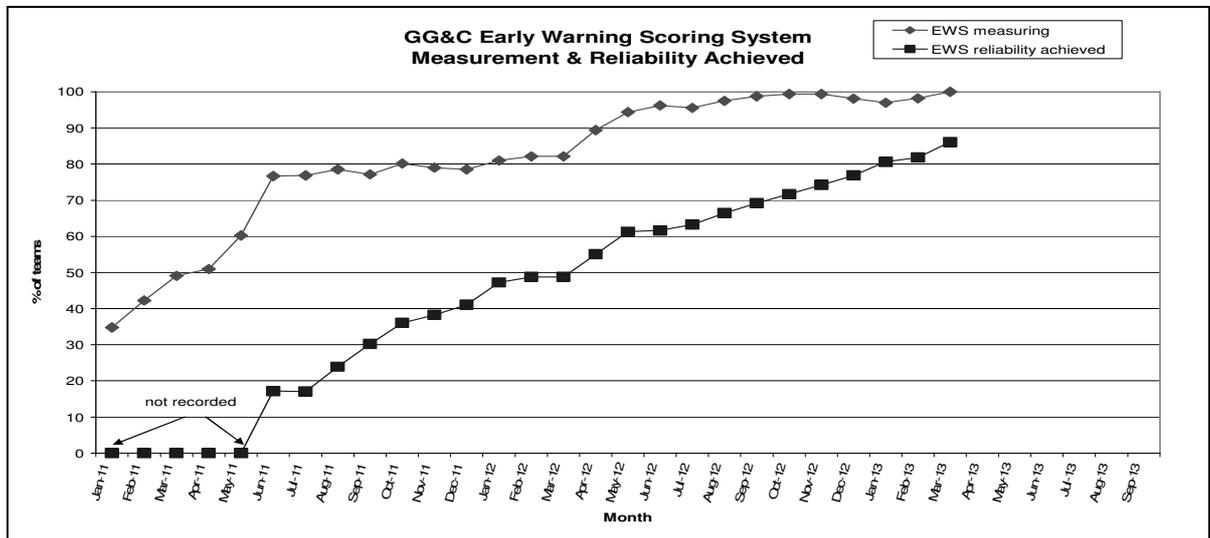
4.7.2. The Sepsis programme was launched this year with an aim of improving the recognition and timely management of Sepsis in acute hospitals in GG&C. The desired outcome is a reduction in mortality from Sepsis of 10% in the pilot population by December 2014. A group of pilot teams was recruited from across the Acute Services Division and we noted there is clinical enthusiasm within NHS for applying the Sepsis bundle to improve care. The new Early Warning Score system and has now been implemented all acute care hospitals. This has the sepsis six bundle written into the reference tool, which will aid awareness and prompt clinical review. As part of implementation nursing staff are receiving the supplementary education on the bundle to underpin effective use of the Sepsis bundle.

4.7.3. The Clinical Governance Support Unit (CGSU) Clinical Effectiveness Team has supported implementation of the Scottish Patient Safety Programme (SPSP) venous thromboembolism (VTE) collaborative launched in January 2012. There are 10 pilot wards nominated to develop processes around the VTE bundle, 19 teams overall identified to participate in the VTE workstream to date, 6 teams are at the early planning stages. The high level aim is to achieve reliable risk assessment and appropriate thromboprophylaxis administration in 95% of all adult hospital admissions by December 2014.

4.7.4. SPSP was launched in Mental Health and our services agreed to participate in phase one of the voluntary programme where they selected to undertake work on reliable implementation of risk assessment and safety planning. Two wards, Elm Ward, Rowanbank and Rutherford Ward, Gartnavel Royal Hospital have been identified to take the work forward. They are also working on leadership and safety culture, which is mandatory for all boards participating in the voluntary phase of the programme.

4.7.5. The Paediatric programme implementation continued within W&C Directorate with the general ward work stream being spread beyond the pilot areas. All ward areas were actively engaged with hand hygiene and CEWS (Children's Early Warning Score) with a focus now on PVC and Safety Communications (Safety briefings and SBAR). There has been continuing support for the development of a paediatric harm index, an idea that was generated following links with Cincinnati children's hospital. The paediatric service began testing of a daily bed huddle process as observed in Cincinnati children's hospital with the first huddle scheduled for January 2012. The huddle is a meeting that lasts approximately 15 minutes with the main focus on patient safety and flow which involves contributions from all clinical areas in RHSC and Ward 15 at RAH to give a service wide picture of activity and safety issues which will assist in predicting and managing patient activity and flow. The aim is to be predictive rather than reactive and support a team culture and will ink well to the safety briefings at ward level.

4.7.6. The locally developed programme in Primary Care was set up to engage General Practice and District Nursing services in improving safety. An example of a local perspective is from Renfrewshire CHP who participated through a GP practice and two Community Nursing Teams to explore different aspects of patient safety and share learning including Medicines Reconciliation, Insulin Safety and Tissue Viability. The participants acquired skills in general improvement methodology for identifying, reporting and reducing harm in primary care. They developed knowledge of quality improvement methodologies and create a patient safety culture using:
- Small tests of change - plan do study act (PDSA)
- Reliable methodology bundles of care
- Process mapping.
The CHP identified that both the results and the staff experience have been positive.

4.7.7. A new member of the SPSP family, the Maternal Quality Care Improvement Collaborative (MCQIC), was launched on the 7th and 8th March; the umbrella term takes in the already established Paediatric programme and emerging neonatal work stream but the focus of this briefing note is on the maternal care work stream. The launch event highlighted the national aims for the work stream and shared draft change packages for implementation. The main aims are:
- To reduce the number of avoidable adverse events in woman and babies by 30% by 2015, and
- To increase the percentage of woman satisfied with their experience of maternity care to >95% by 2015
National funding was provided to support allocation of a maternity champion on each site on a fixed term basis; these posts are in place on each site working 2 days per week to support MCQIC activities. This is a different model from previous collaboratives which have not had specific funded posts to support and requires a slightly different approach to the programme to ensure maximisation of these roles.

5. Clinical Effectiveness

5.1. Clinical effectiveness is a term used to refer to any activities which have as their focus the measuring, monitoring and improving of clinical care. Clinical effectiveness is a major component of 'clinical governance'. These activities include developing and disseminating evidence based clinical guidance and standards, education and implementation planning, measurement through traditional clinical audit and key indicators and reporting-learning activities.

5.2. This section of the report provides a summary of

- Progress against the 2012 Clinical Effectiveness work plan
- Implementation of the Clinical Guideline Electronic Resource Directory
- Support to quality improvement within the Acute Services Division (ASD) 2012
- Improvement summary
- Key planned developments for Clinical Effectiveness work plan for 2013-2014

5.3. In the Clinical Effectiveness Work Plan the key achievements for the clinical effectiveness team in 2012 are:

5.3.1. Support to the measurement and quarterly reporting on standards of record keeping in the Acute Services Division. The Clinical Effectiveness team in collaboration with nursing services in the Acute Services Division completed a retrospective case record audit. A total of 1014 records were reviewed and reported on at the Acute Services Division Clinical Governance Forum in December 2012. A corporate action plan for improvement is in place which will be monitored via the Forum.

5.3.2. Maintenance of an accurate register of "live" national audits. This ensures that publication dates are available and reports disseminated appropriately, so that improvement work can be planned accordingly. A system has been developed whereby the Clinical Effectiveness team maintain the system which is housed on the CGSU web pages.

5.3.3. The development and testing of quality improvement planning documentation and an electronic system to enable more effective capturing of improvement activity.

5.3.4. Supported Healthcare Environment Inspectorate (HEI) Older People In Acute Care (OPAC) inspections to four hospitals. This includes support to the whole process, from, notification of inspection to the development and monitoring of action plans.

5.3.5. A cancer audit support group work plan is developed each year and cancer audit staff have been working throughout the year to complete the objectives outlined within this (see separate report on cancer audit).

5.4. NHSGG&C recognised the need to improve the processes for clinical guideline development, approval and review. The Clinical Governance Implementation Group (CGIG) commissioned the development of a framework to support the development, approval and review of clinical guidelines and an electronic directory to enable storage and retrieval. A joint collaboration between the Clinical Governance Support Unit (CGSU), Pharmacy & Prescribing Support Unit (PPSU) and the Health Information & Technology Directorate resulted in the development of a NHSGG&C Clinical Guidelines Framework and Electronic Directory. An organisational launch of the framework took place on the 2nd April 2012 and the directory has been available on Staffnet since May 2012.

5.4.1. The Clinical Guideline Framework incorporates in its scope both medicine and non-medicine related clinical guidelines. There are currently 204 clinical guidelines posted on the NHSGG&C Clinical Guidelines Electronic Directory. Work has been undertaken to scope out clinical guidelines applicable to the Acute Services Division hosted on other pages within Staffnet and

the process of migration to the electronic directory is underway. There are on average 100 hits, from 50 distinct users per day on the directory. The most frequently accessed clinical guidelines are the gentamicin and vancomycin dosing calculators.

5.5. In supporting Clinical Governance Related Guidance the Clinical Governance Support Unit (CGSU)

5.5.1. Disseminates a monthly newsletter outlining all new clinical governance related guidance which the NHSGG&C Policy for Addressing Clinical Governance Related Guidance covers. This is e-mailed out across NHSGG&C to a core distribution list and made available via the CGSU Intranet site.

5.5.2. Emails a notification of the publication of new guidance to a core distribution list using standard communication. This email outlines the organisational response expected as outlined in the NHSGG&C Policy for Addressing Clinical Governance Related Guidance.

5.5.3. Supports Healthcare Improvement Scotland (HIS) standards, whereby the Board Clinical Governance Forum nominates leadership arrangements for the standards and commissions a baseline self assessment and the development of an NHSGG&C action plan, to support implementation of the standards.

5.5.4. Directorates/Partnerships should ensure completion of an initial impact assessment of the guidance within 3 months of publication through a locally agreed process

5.5.5. Maintains a system across NHSGG&C for tracking the impact assessment process for the following publications:
- SIGN Guidelines
- NICE Interventional Procedures
- HIS Principles and Recommendations
- NICE Non Drug Related Health Technology Appraisals (TAs)

Table 1: Clinical Governance Related Guidance (Published April 2012 to March 2013)

Type of guidance	Number published
HIS Standards	0
HIS Draft standards	0
HIS Quality Indicators	3
HIS Best Practice Statements	0
SIGN Guideline	6
SIGN draft guidelines for consultation	4
NICE clinical guidelines	19
NICE Interventional Procedures	29
NICE Public Health Guidance	6
NICE Cancer Services Guidance	0
NPSA – alerts/ rapid response reports	0
Total	**67**

5.6. The range of work supported by the Clinical Effectiveness team mainly focuses on directorate priorities as identified in the Directorate Clinical Governance work plans, and local projects specific to component services. The number of cross Directorate/Division wide projects being supported by the clinical effectiveness team has remained almost static at 14 in 2011 and 15 in 2012.

5.6.1. Demonstrable quality improvement can be difficult to quantify as many of the projects supported during 2012 have not re-measured the impact of change.   For the purposes of this report, demonstrable quality improvement is taken to mean that either time series data is

available or that an action to improve care has been completed. The following tables present an overview of activity in 2012. In summary:

- The number of projects supported by the Clinical Effectiveness team in 2012 has remained static, 208 in 2011 to 201 in 2012/13.
- The number of abandoned projects has remained static at 19.
- The number of projects completed has fallen from 69 in 2011 to 50 in 2012/13.
- 20 projects resulted in improvement i.e. actions were taken forward, or further cycles of audit showed improvement.

5.7. Some examples of quality improvement projects are as follows

Lead Service	Improvements made
ECMS	Improvement in Emergency Department staff awareness and compliance of Child Protection Guidelines. The rate of awareness improved from 89% to 93%. Formal training of staff rose from 53% to 62% New guideline published - provides staff with guidance on how to approach the subject of Gender-based Violence (GBV) with patients and what to do if someone has experience GBV Increased use of care bundles / pathways for the management of DKA emergencies within the first 4 hours of presentation up to discharge increased from 92% to 98%. Improved compliance against HIS Standards for nutritional assessment, screening and care planning of patients
RAD	Significant improvement in compliance with falls risk assessment from 49% to 96%. The rate of compliance for the falls prevention environmental interventions also improved from 76% to 99%. The use of a Relatives Communication Sheet (RCS) assisted in improving the recording and sharing of information provided to staff by relatives and/or carers. Directorate wide missed doses decreased from 4.8% to 4.0%. This improvement has contributed to a reduction of patient harm through the omission or delay of critical medicines. The Nursing Documentation audit has shown improvement from 79% to 84% in completion of all sections of the nursing documentation

East Renfrewshire	**East Renfrewshire Recovery Service: Service User Evaluation**
	
	In 2012, Alcohol Focus Scotland undertook an independent evaluation of the new community recovery service. The evaluation aimed to assess the extent to which the service is appropriate to deliver on the stated outcomes, to compare and contrast staff and service user views on the delivery of service and to identify the key elements and processes which have impacted most on the service user's recovery. The findings of the evaluation were very posititve and evidenced good progress towards all the stated outcomes since the service was established. In particular, service users felt that they 'owned' their recovery and that the service was working with them rather than 'doing to' them.
	    - 85% of service users reported making good progress with their recovery
	    - 77% reported improvement in their mental health
	    - 69% reported improved physical health
	    - 69% reported improved self confidence and self esteem
	    -
	The findings of the evaluation were presented by Recovery Service Users to the

Lead Service	Improvements made
	Community Addiction Team, the Addiction Planning Implementation Group and Alcohol and Drug Partnership. Local services continue to be developed and increase in staffing capacity of the community recovery service is being sought
Diagnostics	The creation of a unified protocol for the management of pain and nausea for patients attending for uterine artery embolisation (UAE) across sites and wards has improved levels of patient outcomes in relation to pain and nausea.
	Patient perception of pain and nausea following uterine fibroid embolisation showed an improvement or demonstrated an acceptable level of patient satisfaction with outcomes both on the day and follow up within 10 days.
	The revised format for hand hygiene reporting has improved compliance 6% to 91% in 2012.
S&A	The Enhanced Recovery After Surgery (ERAS) programme in colorectal surgery at Southern general Hospital (SGH) has demonstrated improved recovery for patients and improvement in median length of stay following commencement of the programme. The tools developed to support the programme are being rolled out to other sites implementing an ERAS programme.
	Compliance with the falls risk assessment has increased significantly from 78% to 98%. The rate of compliance for the falls prevention environmental interventions also improved from 85% to 95%.
	Management of patient satisfaction, privacy and dignity in endoscopy units has improved through a standardised patient questionnaire and reporting template.
W&C	The use of a quick reference card assisted in improving correct saturation limits on monitors within neonatal resulting in eventual compliance of greater than 90%.
	An increase in thromboprophylaxis was documented and prescribed for women undergoing caesarean section
	An increase in double uterine layer closure for women undergoing caesarean section was noted
	Parents are now receiving an information leaflet prior to first screening for retinopathy of prematurity
	Feedback from patients showed an Increase in number of patients receiving correctly ordered meals on the ward (Obs/Gyn)
	Feedback from patients showed an increase in patients satisfaction in temperature of meals received on the ward (Obs/Gyn)

5.8. Key Planned Developments for 2013 / 2014

- Place the principle and practice of being person centred more clearly at the heart of our improvement approaches.
- Continue support for the SPSP collaborative for the prevention of venous thromboembolism (VTE), to support the directorates to improve the delivery of evidence based care in prevention of venous thromboembolism.
- Support members of the clinical effectiveness team and clinical staff to move from a culture of clinical audit as the improvement methodology of choice to consider the use of other quality improvement methodologies, tools and techniques.
- Support the directorates to take forward projects which are more likely to lead to improvements.

- Support the directorates to further develop, implement and strengthen existing governance processes.
- Implement the revised quality improvement project related supporting documentation and database to support the implementation of the NHSGG&C Clinical Governance Strategy & Framework.
- Review the clinical effectiveness training modules to include the model for improvement methodology and to continue to build improvement capability within the Acute Services Division.
- Support the implementation of the NHSGG&C Clinical Guideline Framework
- Further develop a NHSGG&C Register of participation in national audit projects
- Deliver the Cancer Audit Support Group Work Plan for 2013-2014.
- Support the NHSGG&C response to the Healthcare Improvement Scotland Scrutiny Model
- Support the directorates to improve the quality of clinical documentation and record keeping.
- Support the Directorates in delivering the Older People in Acute Care Improvement Programme.
- As part of the Clinical Governance Support Unit (CGSU) objectives for 12/13, a tracking system for clinical quality publications will be developed and implemented
- Support the development and implementation of an ASD missed doses improvement project

6. Strategic reflection on emerging Clinical Governance themes

6.1. It is likely that a focus on safety will continue to dominate the Boards strategy for Clinical Governance in coming years. As we seek to provide greater transparency to the nature of patient's healthcare experience there is greater public and professional appreciation of the challenges in maintaining patient safety in an increasingly complex health and care context. The Boards decision to integrate the traditional focus on clinical risk management with improvement thinking provides a strong base from which our staff can respond to these challenges.

6.2. The establishment of lead responsibilities for the new national Person Centred Health and Care Programme around clinical governance is very much welcomed and gives a major boost to our aim of a greater focus on safe effective person-centred care. Lessons from the best performing healthcare organisations around the world suggest this integrated approach is a necessary feature of longer term success in providing high quality care.

6.3. Linked to the ongoing response to the failings of the Mid-Staffordshire Trust in England we expect continued and increased focus on governance mechanisms. Transparency and accountability for our performance against expected clinical standards is an important element of clinical governance. There is an ongoing opportunity for further development of governance processes but we also need to be mindful of the counter-productive aspects of overweighted governance, particularly in respect of human relations whose importance is framed in the national NHS Quality Strategy.

APPENDIX ONE

<u>**EXTRACT OF**</u>
<u>**STATEMENT OF ASSURANCE ON CLINICAL GOVERNANCE ARRANGEMENTS**</u>

NHS Greater Glasgow and Clyde

Statement of Assurance on Clinical Governance Arrangements

(for Clinical Services within NHS Greater Glasgow and Clyde 2012/13)

The Quality and Performance Committee has monitored clinical governance arrangements and developments throughout 2012/13. The Convener of the Quality and Performance Committee and the Medical Director, as designated Executive Lead for Clinical Governance, have joint responsibility for maintaining a sound system that supports the achievement of the aims and objectives of clinical governance. The Board Clinical Governance Forum supports the Executive Lead for Clinical Governance in the discharge of this responsibility.

The Quality and Performance Committee met six times in the last year and, inter alia, monitored clinical governance systems and improvement plans. The membership of the Quality and Performance Committee comprised Mr I Lee (Convener), Dr C Benton MBE, Ms M Brown, Mr P Daniels OBE, Mr I Fraser, Cllr M Kerr, Cllr A Lafferty, Cllr J McIlwee, Ms R Micklem, Mr D Sime, Mrs P Spencer BEM, Mr B Williamson and Mr K Winter. As well as the members of the Committee, meetings were attended by other NHS Board members and senior managers.

The minutes of the Quality and Performance Committee meetings are presented to and reviewed by the NHS Board at their regular meetings and then published on the website as part of the Board papers. The Quality and Performance Committee has monitored clinical governance arrangements and developments throughout 2012/13.

Clinical Governance arrangements are kept under continuous review through the functions of the Quality and Performance Committee, the Medical Director as Executive Lead for Clinical Governance and the Head of Clinical Governance; The Chair of the Quality and Performance Committee joined meetings of the main clinical governance forums to explore their working and the way in which each forum's activities integrate with the role of the Quality and Performance Committee. The role and terms of reference of the Board Clinical Governance Forum was reviewed and revised to strengthen its assurance functions in support of the oversight role of the Quality and Performance Committee.

An annual Clinical Governance report for 2012/13 is in preparation for approval by the Committee.

Standing items, in respect of clinical governance, discussed during the course of the year by the committees 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

- The Integrated Quality and Performance Report, which links a range of performance measures including clinical outcomes, finance, service performance, and patient and staff views

- 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

- Reports on Infection Control programme and performance indicators

- Reports on the Ombudsman's recommendations associated with NHS Greater Glasgow and Clyde

A range of quality and safety related items were also selected as issues became prominent, with such items discussed at individual meetings.

Based on our review of this work, we would conclude that the Quality and Performance Committee has, in respect of the year ended 31 March 2013, properly discharged its responsibilities insofar as they relate to clinical governance and there was a satisfactory system in place throughout the year to provide reasonable assurance of the effectiveness of the arrangements for clinical governance.
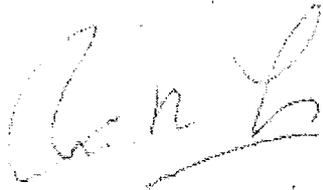
Ian Lee
Convener of Quality and Performance Committee

Date: 17/6/13

Jennifer L Armstrong
Medical Director

Date: 6 June 2013