NHS Greater Glasgow & Clyde

NHS BOARD MEETING

Dr J. Armstrong, Medical Director **19 April 2016** **Paper No: 16/11**

Clinical Governance Update

Recommendation:-

The Board is asked to:

- Review and approve for publication the NHS GG&C Clinical Governance Policy
- Note the development of specific objectives for the Board Clinical Safety Programme
- Note the recent feedback from Healthcare Improvement Scotland on local implementation of the Acute Adult Care programme of the Scottish Patient Safety Programme

Purpose of Paper:-

This report raises for the Boards attention one critical area (approval of the Board Clinical Governance Policy) and two important areas (developing local safety programme objectives and feedback on SPSP Acute Adult Care programme).

Key Issues to be considered:-

The development of the Board Clinical Governance Policy with the Board being the final approval required prior to publication

The creation of specified objectives local objectives to better describe and understand progress in implementing SPSP

Encouraging feedback on areas of SPSP implementation in the Acute Adult Care programme.

Any Patient Safety /Patient Experience Issues

Yes – as part of this report relates to the clinical safety programmes – describing the approach to improving safety

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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Clinical Governance Update Report for

NHS GG&C Board meeting of 19 April 2016

1. Introduction

There is ongoing work to develop a more complete report reflecting a much broader scope of the clinical governance arrangements, activities and assurance framework. In the meantime this report raises one critical area (approval of the Board Clinical Governance Policy) and two important areas (developing safety programme objectives and feedback on SPSP Acute Adult Care programme).

2. NHS GG&C Clinical Governance Policy

Each Healthboard in NHS Scotland is expected to maintain and publish a corporate document setting out its approach to the Duty of Quality, more commonly referred to as *Clinical Governance*.

The latest version of the Clinical Governance Policy (attached as **Appendix 1**) was developed to reflect the changes in NHS GG&C including the establishment of the Health and Social Care Partnerships. It also reflects the observed shifts in NHS Scotland towards increasing emphasis on external scrutiny. The Policy was subjected to an organisational consultation process before being finally endorsed at the Board Clinical Governance Forum for presentation to the NHS Board.

Board members are asked to approve the NHS GG&C Clinical Governance Policy for publication.

3. Board Safety Programme Key Objectives

One of the challenges in applying the national measurement strategy for SPSP has been difficulty in adequately demonstrating progress within local implementation. The ability to show progress based on outcome measures is limited because of a number of factors, most notably that they are not set for every programme, they can be difficult to measure and outcomes may be linked to many more factors than are being improved in the work-stream. The process measures are vital for teams to understand the impact of their planned changes but can become meaningless when they are aggregated across the scale of the Board. As part of the gradual development towards the Board's own safety programme we have developed a more specific set of objectives. These are intended to focus our monitoring process so we can be clearer about required actions and progress.

Board members are asked to note the more specific description of objectives as follows and the expectation these will help form a more explicit focus on actions required to meet the objectives and assist in reporting on progress.

Deteriorating Patient Work-stream
The ASD sectors and directorates will create a spread plan for the deteriorating patient work-stream, which will, o Ensure those wards reporting the greatest frequency of crash calls in

each hospital are active in the programme (this will cover those locations reporting 60% of all crash calls) o Ensure the wards in this start up cohort are demonstrating a reliable clinical process for early warning score and structured response. o Ensure the emergency departments and admission/assessment wards are able to demonstrate a reliable clinical process for Sepsis six
The ASD sectors will ensure the measurement of the rate of cardiac arrests is provided for each hospital
The ASD sectors and directorates will ensure there is a system in place for the review of the care of patients requiring a crash call that links to local M&M and Clinical Governance arrangements
Medicines Reconciliation
Ensure all clinical teams currently engaged in the workstream demonstrate a reliable medicines reconciliation process and accurate prescription chart within 24hrs of admission
Ensure there is a spread plan that means all target clinical teams are actively engaged in the workstream to improve medicines reconciliation within 24hrs of admission
Ensure there is a plan that means 50% of clinical teams are actively engaged in improving medicines reconciliation at discharge
Ensure all GP practices and GP clusters demonstrate a reliable medicines reconciliation process by achieving $\geq$ 95% compliance with primary care meds rec care bundle

Background on Deteriorating Patient work stream, including Sepsis

The Deteriorating Patient work stream was launched in 2012 as part of the Acute Adult Scottish Patient Safety Programme (SPSP).

The overall aim of the work stream is to reduce cardiac arrests in general wards settings, by improving the response to and review of deteriorating patients. Evidence suggests that patients who are, or who become, acutely unwell in hospital may not always receive optimal care. This might be because the deterioration is not recognised, it is not appreciated, or it is not acted upon quickly enough. Communication between healthcare providers is often poor and provision of expertise or higher level care is sometimes delayed because of this.

There are 3 key “drivers” to support the aim,

1) early anticipation, decision making and care planning

2) implementing a response for a patient who deteriorates; and

3) ensuring the appropriate infrastructure is in place to support anticipation and response.

Wards who are active in the work stream are asked to collect 2 measures to demonstrate that they have reliable processes in place; these are 1) percent compliance with early warning score -correct frequency of observations (goal –95% or greater); and 2) percent compliance with structured response (goal –95% or greater). The outcome measure for the work stream is the number of cardiac arrests.

The deteriorating patient work stream has been identified as a safety priority for the Board, and a number of safety objectives have been agreed. These focus on spreading the work

stream within the acute setting, ensuring measurement systems are in place, and ensuring wards working on the programme achieve reliable care processes.

The SEPSIS workstream was initially launched as a standalone programme of work in 2008, but was incorporated into the deteriorating patient work stream in 2012 when the Acute Adult Safety Programme was launched.

People with severe sepsis are likely to be very ill and the condition can be fatal. However, if identified and treated quickly, sepsis is treatable, and in most cases leads to a full recovery with no lasting problems. The overall aim of the SEPSIS workstream is to reduce mortality and harm from SEPSIS, by improving recognition and timely delivery of evidence based interventions. Mortality from sepsis and severe sepsis increases with each hour of delay in initiating intravenous antibiotic therapy. In patients with sepsis, the aim is to complete the "Sepsis 6" within 1 hour: This includes 1) oxygen therapy (target saturation 94 - 98% or 88 - 92% for those with COPD); 2) IV fluids (at least 500 ml sodium chloride 0.9% in first hour); 3) blood cultures; 4) commence IV antibiotics according to guidelines; 5) measure lactate; and 6) 6. assess urine output (consider catheterisation in some patients).

There are 3 primary drivers for this work stream 1) reliable recognition & assessment, 2) reliable care delivery; and 3) education & awareness. There are 2 measures for SEPSIS that are reported nationally 1) time to first anti-biotic; and 2) compliance with the bundle overall (Sepsis 6).

The current plan for the workstream is to ensure that all emergency unscheduled care wards and departments across NHSGGC have a reliable system of sepsis management.

Background to Medicines Reconciliation Workstream

When patients are admitted to hospital it is important to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission. This involves taking a careful medication history from the patient, using the most recently available information sources available, resolving any discrepancies and documenting which medicines are to be continued, stopped, with held or changed. Medicines to be continued should be written up in the prescription chart, along with any new medicines started on admission.

An accurate list of the patient's medicines needs to be maintained and documented on the prescription chart during their stay along with details of any changes made and the reason(s) for stopping a medicine. This should be reliably communicated between teams when care is transferred to another ward or hospital and at discharge to the GP.

This whole process of establishing and maintaining an accurate, up to date list of medicines and details of changes from admission to hospital, through transfer and at discharge is known as Medicines Reconciliation

4. SPSP Adult Acute Care Programme Update

The national support team for SPSP, based in Healthcare Improvement Scotland, review the data submitted by NHS GG&C for the Adult Acute Care programme every three months. This is followed up by a visit to discuss areas of challenge and progress. The following is an extract of their most recent feedback report.

- The development of PUDRA for risk assessment and the link with Active Care

rounding. This was shared at the regional learning session with highly positive feedback from the evaluation of that event.

- The progress made on Deteriorating Patients
    - An increase to 20 wards now involved in this work stream
    - The achievements in achieving reliability in 4 wards for frequency of observations
    - The revised approach to producing cardiac arrest data which is now reported from 3 hospitals. The board describes a high degree of confidence in the data from RAH and that data from the new reporting sites cannot yet be considered robust.
    - The measure relating to % crash call forms received which has potential to drive improved reporting
    - Identification of Cardiac Arrest rate as a key clinical indicator for the board.
    - The sustained improvement in delivery of sepsis six and plans to merge with DP work stream in relation to downstream wards. The board describe plans to review sepsis work stream to understand reliability in receiving areas and address any gaps.
- The significant spread and reliability of CAUTI work stream. The revised reporting template support reporting of catheter usage which may support the board to demonstrate improvement.

PUDRA (pressure ulcer daily risk assessment) has been developed locally and is well accepted by nursing staff. The first feedback point from the HIS team reflects the positive impact of our staff presenting to other NHS Boards on embedding the risk assessment in the active care rounds undertaken by nursing teams across Acute Services. This has helped maintain the high reliability of the daily risk assessment being undertaken.

PUDRA helps to identify a person at risk of developing a pressure ulcer. It focuses on a collection of factors which are known to lead to pressure ulcers developing. PUDRA records a pressure ulcer daily risk assessment on the front page and there is an interventional plan of care on the back page for people who are identified at risk; have redness; or existing pressure damage.

Although the Acute Services Division has set a number of challenging objectives to accelerate the deteriorating patient work-stream the second feedback point describes a number of positives in the current work-stream approach.

The scale of reliable spread of clinical practice linked to the Cather Associated Urinary Tract Infection (CAUTI) work-stream has been the most significant of any in the Programme. This is also noted by the HIS team in the third feedback point.

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

The Board members are asked to note the mainly encouraging feedback from the review provided by Healthcare Improvement Scotland.

Appendix 1

IMPROVING & ASSURING the QUALITY of CLINICAL CARE

The NHS GG&C Clinical Governance Policy

NHS GREATER GLASGOW & CLYDE	Approval: NHS Board
Responsible Director: Medical Director	Custodian: Head of Clinical Governance
Issue date: March 2016	Status: Draft for Board Approval
Version: 4.9	Review Interval: 3 years

Contents

1. Introduction

1.1. Our commitment to improving the safety and quality of care is central to the way we work within NHS Greater Glasgow & Clyde (NHS GG&C). Our ambition to provide high quality care is informed by the statutory Duty of Quality.

1.2. The Health Act 1999 requires that NHS GG&C;
"put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals" **.**

1.3. The Duty of Quality applies to all services we provide in connection with the prevention, diagnosis or treatment of illness. It includes services that we jointly provide with other organisations. Essentially NHS GG&C must satisfy this duty of quality through internal arrangements and also through effective collaboration with partner organisations.

1.4. 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.** Although the Duty of Quality is a prominent driver we must take account of many other legislative and national policy requirements which have a major impact on the quality of care experienced by patients, carers and families. For instance, it is well recognised that we cannot provide a high quality health service if it is not adequately sensitive to the issues of inequalities.

1.5. The purpose of this document is to set out the key policy requirements and the organisational arrangements for NHS GG&C.

1.6. Please note the policy is written at a level of key requirements and principles. The important issues of implementation and practice will be supplemented by the publication of other supporting guidance, providing greater detail on specific quality improvement or governance practice and methods (see Staffnet site for more details directly accessible at (INSERT LINK)

2. Policy Context

2.1. The major aspect of Clinical Governance is how we collectively and continuously improve the QUALITY of clinical care we provide.

2.2. In 2010 NHS Scotland published the national Healthcare Quality Strategy which raised a challenge for every NHS board. It states "the ultimate aim of our Quality Strategy is to deliver the highest quality healthcare services to people in Scotland". This aim was developed further in the expectation that "we want confidence for patients that their NHS is amongst the best in the world – safe, effective and responsive to their needs, every time and all of the time".

2.3. The increasing evidence from many other industry sectors as well as healthcare is that quality must be core to any successful business strategy. We also observe from studies of high performing healthcare organisations across the world that improving value and efficiency is inextricably linked to improving quality and reducing harm. Our intention is to provide for patients care they highly value by ensuring reliability and consistency, building confidence and reputation and being responsive to the needs of the people being served.

2.4. The Scottish Government Health Directorate and other agencies such as Healthcare Improvement Scotland and the Care Inspectorate carry national support roles for guidance, improvement support and scrutiny. All NHS GGC developments should acknowledge the ongoing output of the key national reference points in framing local approaches to healthcare improvement.

2.5. Clinical governance arrangements must also integrate effectively with other structures to create shared ownership of decision making, particularly between patients and families, general managers and clinical professionals, in which there is shared responsibility for practice and for responding to all wider organisational priorities to deliver a safe effective and person centred service.

3. Policy Aim

3.1. Our aim in improving clinical quality, aligned to the NHS Scotland Quality Strategy, is:

To reliably provide safe effective person centred care for every person.

3.2. Our aim in monitoring clinical quality, aligned to the principles of good governance, is:

To engage and involve people in ensuring clinical quality is associated with public transparency and meaningful accountability.

4. The NHS GG&C Clinical Governance Policy Requirements

4.1. Overall the Policy defines our approach to clinical governance. Its implementation is dependent on a collective framework of organisational contributions. Successful implementation will ensure that there is an organisational focus on improving and assuring clinical quality that includes:

- the scheme of accountability across all areas within NHS GG&C, and any delegation to partner organisations, for the quality of clinical services and practice;
- the structure and constitution of key groups through which objectives and priorities are set, monitored and reported on;
- the resources, methods and activities that seek to improve the quality of clinical services and practice (This includes the expression and monitoring of clinical

standards, engaging and learning from the patients, learning from errors and adverse events, etc.)
- the controls assurance environment including rules and procedures for making decisions (e.g. in policies and procedures);
- the effectiveness of relationships in building collaboration across distinct but complementary functions and responsibilities; and
- the underpinning organisational values, behaviour and practices.

5. The Scheme of Accountability

5.1. The Chief Executive has overall responsibility for the delivery of clinical governance and will discharge this responsibility through the organisational structure of accountability for the quality of care. The primary line of organisational accountability for the quality of care sits in the line of general management. This is complemented by the Board governance arrangements including Executive leadership, clinical governance structures and professional leadership frameworks for clinical disciplines.

5.2. The NHS GG&C Board, including any delegated roles and responsibilities held by other corporate committees, is responsible for maintaining an overview of Clinical Governance and ensuring the provision of assurance to the public that the NHS GG&C arrangements to improve and assure clinical quality are effective. The Non-Executive role contributes to building public assurance that an appropriate system is in place for development, implementation, monitoring and review of clinical quality, which ensures that clinical governance arrangements are working effectively in safeguarding patients and improving the quality of clinical care.

5.3. The responsibility for the strategic development and assurance of effective arrangements is delegated to lead Executives, who will work in support of the Chief Executive. The Board Medical Director is the executive lead for clinical governance, working with the Board Nurse Director, and has overall executive responsibility for clinical governance within NHS GG&C.

5.4. This triad of Chief Executive, Non-Executive and lead Executive, frame the collective corporate responsibilities that will make sure NHS GG&C is:

a. ensuring the clinical governance policy and extended arrangements produce demonstrable benefits to patients and links to the three overarching goals of NHS GG&C- to improve health, to improve health services and to tackle inequalities.
b. demonstrating the implementation of the national legislative and mandatory quality improvement requirements e.g. key statutory requirements, NHS circulars, NHS HIS standards.
c. ensuring we are identifying and sharing knowledge on the key organisational priorities
d. ensuring that all services respond fully to concerns of sub-optimal care including appropriate escalation or communication on investigation and improvement processes to general management and corporate assurance arrangements

e. ensuring that all services have in place prioritised clinical quality improvement programmes through which they are applying clinical risk management, process reliability, audit, evaluation, or other quality improvement methods, which will sustain and improve the delivery of safe, effective person centred care
f. ensuring that all quality improvement programmes engage with patient families and staff to ensure all approaches are person centred
g. engaging with NHS HIS, or other inspectorate agencies, and collaborating on all aspects of clinical standards or service reviews
h. ensuring that NHS GG&C works collaboratively, internally and with partners, to identify priorities for and approaches to quality improvement
i. ensuring there is a scheme of reporting that supports transparency and public accountability including information formally required by the Scottish Government Health Directorate or Healthcare Improvement Scotland on clinical governance activities.

5.5. Accountability for the delivery of clinical governance within the Acute Services Division rests with the Chief Officer who will discharge this responsibility through the local management structure. The responsibility for the development and assurance of effective arrangements is routinely delegated to and supported by the designated clinical governance leads.

5.6. Within Health and Social Care Partnerships the Integrated Joint Board and Chief Officer is accountable for ensuring the clinical and care governance requirements specified in the approved integration schemes are appropriately discharged. Section 5.7 is advocated as a description of requirements (in addition to the approved integration schemes), which will support the Integrated Joint Boards meet the Duty of Quality and enable the Chief Officers to provide assurance on clinical governance to the Medical and Nurse Director and Chief Executive. The following outline of responsibilities must be applied in a manner that reflect the specific nature of services in joint settings and appreciates that adaptation is required to embrace the concepts of shared care governance that exists with Local Authority partners. However the requirements will be the basis for the provision of assurance and communication with Executive Directors on the appropriateness of local arrangements.

5.7. The NHS GG&C Acute Services Division and Integrated Joint Boards have responsibility to:

a. maintain local leadership arrangements that ensure the requirements of clinical governance are embedded in services and are in line with related Board policies, making clear the accountability for key clinical risks or quality priorities associated with their services
b. make sure all services comply with the statutory requirements and duties with reference to appropriate national standards for clinical governance and patient safety (including those commissioned from contractors or jointly provided with other organisations)

c. make clear the joint accountability arrangements for improving quality in services which are provided on a multi-agency, multi-sector basis and involve any partners in service provision within clinical governance activities
d. demonstrate behaviours and ways of working that systematically improve the safety, effectiveness and person-centeredness of clinical care, practice and services including clear safety priorities and knowledge of the effectiveness of the improvement strategies
e. ensure that any emerging concerns over the quality and safety of care or services are recognised rapidly and escalated to ensure corporate awareness - thereafter each concern is fully reviewed and appropriate improvement plans are established, monitored and communicated
f. ensure that all improvement projects are designed and managed in line with prevailing evidence based knowledge on quality improvement
g. ensuring all clinicians and clinical teams are regularly involved in planned activities to improve the quality of clinical care
h. apply key clinical quality and clinical outcome measures in local monitoring arrangements
i. ensuring that all quality improvement activity is patient and carer focussed taking special account of inequalities sensitive practice
j. develop an open and just culture within the organisation where incidents are reported and lessons are learned
k. maintain processes of professional support and learning which sustains staff knowledge and competence, can detect then responds to concerns of capability or performance or celebrate achievement
l. ensure that all clinical practice and services are sensitive to diversity or inequalities within and across communities
m. ensure adequate reporting arrangements to the Health Board on clinical governance activities that involves the maintenance of a quality improvement plan, which is reviewed and updated regularly then formally evaluated through the published annual report.

6. Support to implementation

6.1. The Board has funded a support team for the Acute Services Division and Partnerships i.e. the Clinical Governance Support Unit (CGSU). CGSU organises staff providing specialist advice and practical support for NHS GG&C services in developing safer, more effective and person centred health care. Although it is managed as a single corporate function its primary role is to work closely with clinical services, supporting and educating staff in the application of clinical risk management and quality improvement methods. It also manages information and reporting that support managers, lead clinicians and key NHS GG&C committees in monitoring the effectiveness of the clinical governance framework. The support role is not exclusive and other services may take the lead in providing support for improvement in key areas e.g. PPSU for safe & effective use of medicines.

6.2. Improving and sustaining high levels in the quality of care experienced by patients is intrinsic to the NHS tradition and an explicit objective of a range of complementary services or functions throughout NHS GG&C. To be successful in achieving the objectives of this strategy it is important to recognise the necessary links, liaison & shared aims between CGSU and other support functions such as Knowledge Services, Organisational Development, Corporate Inequalities Team, Health and Safety, Planning, Performance, Learning and Education, Practice Development, Medical Education.

6.3. The designated lead roles in clinical governance arrangements overlap with the designated clinical leadership roles. There are obvious synergies with the clinical leadership arrangements throughout the organisation. The roles and accountabilities of clinical leaders are designed to augment the professional and corporate assurance mechanisms to ensure the delivery of safe, high quality patient care, (Medical Professional Accountability 2016) .

7. Monitoring the Clinical Governance Policy & Arrangements

7.1. Coordination of the policy and its related activities will be facilitated through the Board Clinical Governance Forum (BCGF). The BCGF is chaired by the Board Medical Director and is responsible, on behalf of the Chief Executive, for developing policy and establishing decisions on strategic priorities deemed essential to improving the quality of care. The BCGF will be directly supported by key groups and relate to others, which will shape and develop clinical governance within NHS GG&C.

7.2. Organisational accountability for the quality of care lies in the primary line of general management for clinical services. Therefore monitoring/evaluation of the operating standards and improvement plans for the clinical governance framework must be integrated with the primary line of general management and the associated planning/performance review processes. This is complementary to the BCGF and various Clinical Governance Forums, linked to the corporate oversight role of the NHS GG&C Board and its standing committees.

7.3. To confirm the development of clinical governance that supports learning within NHS GG&C and provides assurance on the standards of clinical quality, the key committee/groups (i.e. Acute Services Committee and Board Clinical Governance Forum) will inquire through reports from clinical services and their supports. This routine of inquiry must be consistent with and supplementary to the requirements of other monitoring arrangements, including those for Health & Social Care Partnerships.

7.4. Monitoring reports from Acute Services Division, Health & Social Care Partnerships or corporate services e.g. Public Health, to review progress against their local quality improvement plans and key performance indicators will be coordinated through the Board CGF.

7.5. The Acute Services Division and Health & Social Care Partnerships will ensure reports reflecting progress and clinical governance activity are easily accessed and an annual summary is published at the end of each calendar year. Publication will include submission to the Medical Director and availability to the public. They will support the development of assurance declarations underpinning the Statement on Internal Control and will be reflected in the NHS GG&C Annual Report for Clinical Governance.

7.6. NHS Greater Glasgow and Clyde will also use a variety of internal and external mechanisms to monitor and evaluate the effectiveness of the Clinical Governance Framework. These will include:

- The use of internal evaluation reports from specialist staff;
- The use of external assessment reports from bodies such as NHS Healthcare Improvement Scotland, Audit Scotland, Mental Welfare Commission;
- The use of benchmarking or reports providing comparison with others Boards and Services
- The use of independent internal audit reports;
- Contract monitoring reports on the service quality of independent contractors;
- The use of self assessments or independent assessments against standards e.g. Faculty of Public Health Guidance, NHS HIS publications & reviews, the GMC trainee and trainer surveys.
- Local Delivery Plan reviews.

7.7. The effectiveness of the overall framework and its constituent elements will be evaluated and shared with the Board on a regular basis, notably through the Annual Report and Clinical Governance Improvement Plan. This will draw on the evidence available from the various mechanisms described in the preceding paragraph.