

Update Report on Clinical Governance in NHS GG&C

Recommendation:-

The NHS Board is asked to:

1. Review the content of the update report and advise on areas where the information supports assurance, or requires further development;
2. Advise on how this report can be developed to ensure that it:-
 - a) represents the fullest scope of clinical governance;
 - b) supports Non Executive oversight and accountabilities for clinical governance;
 - c) informs assurance processes, monitoring and reporting at the corporate levels.

Purpose of Paper:-

Assurance reporting as part of the Board's clinical governance process is currently being redeveloped, using a new consolidated overview report. The aim is to reflect more adequately the full scope of clinical governance. This report is developed from this new format. The content and structure was initially reviewed at the Board Clinical Governance Forum, which was in turn used as the basis for a report to the Acute Services Committee.

The purpose of this report is to test how it may also inform reporting to the NHSGGC Board.

Key Issues to be considered:-

During a recent development visit, Healthcare Improvement Scotland noted a number of positive features of the clinical management system which is in place in GGC.

The process for clinical incident review and designing subsequent improvement projects to ensure that learning is sustained is illustrated for medicines safety events in acute care.

There is also a number of procedural improvements to enhance incident management in mental health services and these are set out.

There is acknowledgment that there is a need to improve the sharing the knowledge of clinical risks, improve ways to effectively control and thereafter, subsequently reduce the level of clinical risk.

The arrangements for ensuring the consideration of external and internal clinical publications are operating robustly and a range of good practice is highlighted.

The report illustrates various different means where staff in GGC are collecting patient feedback on their experience of our services.

The numerous work-streams associated with the Scottish Patient Safety Programme are briefly outlined. Steady progress is observed across many areas of the clinical safety work - two common themes across reported issues are

1. the challenge of supporting more clinical teams as each work-stream seeks to increase in scale, and
2. data management support with the use of information technology to ease this challenge.

Any Patient Safety /Patient Experience Issues

Yes.

Parts of this report relates to the clinical safety, describing the approach to improving safety, and to patient experience, describing some current feedback mechanisms.

Any Financial Implications from this Paper

None specified

Any Staffing Implications from this Paper

None specified

Any Equality Implications from this Paper

None specified

Any Health Inequalities Implications from this Paper

None specified

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

None specified

Highlight the Corporate Plan priorities to which your paper relates

The high level aim

- improving quality, efficiency and effectiveness and the supporting objective
 - making further reductions in avoidable harm and in hospital acquired infection;

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Greater Glasgow and Clyde NHS Board

OVERALL CLINICAL GOVERNANCE REPORT (for NHS Board Meeting June 2016)

Introduction

As part of a general plan to improve the clinical governance process we have created a new consolidated overview report. This is to more adequately reflect the full scope of clinical governance. This report is therefore a new format for the board. It has been tested initially at the Board Clinical Governance Forum. This was then used as the basis for a report to the Acute Services Committee. We are now testing it as a basis for reporting to the Board of NHSGGC.

The NHS Board members are asked to

- Review the content and advise on areas where the information supports assurance, or requires further development,

then advise on how this report can be developed as a product which,

- Represents the fullest scope of clinical governance
- Supports Non Executive oversight and accountabilities for clinical governance
- Informs assurance processes, monitoring and reporting at the corporate levels

Background

The Health Act 1999 requires that NHSGGC;

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

NHSGGC must satisfy this duty of quality through maintenance of clinical governance arrangements, which includes effective collaboration with partner organisations.

This report will be provided to the NHS Board on a quarterly basis and is intended to describe notable progress and challenges in the maintenance of clinical governance. The report is structured around seven domains of clinical quality and governance as follows:

- Clinical Safety
- Clinical Effectiveness
- Person Centred Care
- Clinical Governance system and leadership
- Quality Improvement
- Training and education of workforce
- Information and IT for clinical governance

1. Clinical Safety

Clinical Risk Management

1.1 The Acute and Partnerships Clinical Risk Papers for Oct – Dec 2015 were reviewed as the basis for these key message with the full reports available on request for Board members.

Acute:

- The level of significant clinical incidents reported in the South Sector was reviewed and confirmed it is in relation to scale of services provided rather than change in the risk levels. A comparison with the previous hospitals now amalgamated in the South Sector demonstrates there is no rise in the level of reported events. This observation has been mirrored in the North Sector where services were re-configured. The clinical risk team analysed data for the preceding year for the sector and found no variance.
- Key themes in significant incidents remain consistent across recent quarterly reviews, with medicines incidents in the acute sector and suicide incidents in partnerships being the areas where most improvement work and learning is generated.
- Medicines incidents are currently testing the national learning template to translate lessons learnt across the acute sectors and directorates and are published nationally on the Adverse Event Framework Community of Practice.
- Medicines system failures identified through the investigation of the Significant Incident Reviews has generated improvements in the various medicines systems, examples being the introduction of a Gentamicin prescribing and monitoring chart, standardised insulin documentation charts, on-line dose calculators, apps to support access to handbooks and sepsis recognition
- Medicine reconciliation incidents continue to be an issue and this weakness in our systems is being addressed by the medicines reconciliation improvement programme
- A review of the reasons for delay in completing incident investigations was carried out and concluded that the majority of delays are caused by staff supporting the investigation not being able to dedicate time due to workload commitments, and this challenge can be found board wide.

Partnership:

- A better review process for confirming improvement actions are completed has been established, and covers the whole of Mental Health using the Mental Health Executive Group to coordinate.
- Partnership wide actions identified through significant clinical incidents reviews are now assigned to individuals at the Mental Health Executive Group. The clinical risk team monitor the progress of these actions and advise service when action dates are breaching.

1.2 How we are improving it (links to quality improvement)

There is recognition that although much work has been done to ensure the quality of Significant Clinical Incidents (SCIs) investigations and the monitoring of recommendations there are still areas for improvement.

These 2 key areas were discussed at the Acute Clinical Governance Forum and are:

- Sharing Learning – within hospitals (cross specialty) and within specialties (cross site).
- Evaluating solutions – once an action has been taken following an SCI how do we know the difference this has made without waiting for a similar event happen?

All agreed that these were difficult issues to resolve and potential solutions were discussed such as:

Sharing Learning

- More use of learning summaries to make information easier to share (currently tested for medication incidents).
- Cross site specialty groups discussing recommendations from relevant SCIs to ensure cross site awareness and implementation of actions if required.

Evaluation solutions

- To more effectively monitor solutions through specialist groups such as; Venous Thromboembolism, Falls Governance, Safer Use of Medicines Committee so this can be linked to improvement initiatives.
- To encourage safety audits within services to check implementation of recommendation has been successful monitored via Clinical Governance work plans.

The Clinical Risk Team are continuing to work with services to try to improve this aspect.

- To share learning Healthcare Improvement Scotland (HIS) Adverse Events Network developed a learning summary template, clinical risk staff have been highlighting the template to clinical governance groups and will develop a process for approving these and uploading to the Community of Practice website
- Local learning events are arranged, our recent event in Mental Health discussed learning from suicide reviews and received feedback from staff and a family
- Patient Safety Bulletins are produced quarterly with extracts from learning and recommendations
- Monitoring solutions and audit.
- In mental health, a key theme from SCIs highlight that risk assessment and communication at transitions as the highest contributory factor and these are both workstreams in the Mental Health Safety Programme
- Clinical risk monitor open and closed actions and report on these to specific governance groups, analyse questionnaire results from staff involved in SCIs for policy review and ensure that families are involved in all SCIs where appropriate. In addition, developing evaluations for families involved in the process to gain their feedback

1.3 Internal and external assurance (eg our own reviews and external reports)

Healthcare Improvement Scotland (HIS) have been reviewing NHS Board's compliance with the National Adverse Events Framework. NHSGGC was commended for:

- Sharing learning summaries nationally
- Training provided for Significant Clinical Incident reviews
- Linking Significant Clinical Incident with the complaints process. There is now a working protocol between the clinical risk and complaints team which has standardised the approach when a significant clinical incident is identified within a letter of complaint
- Evaluation compliance with the framework (patient involvement, quality of review, timescales)
- Not only concentrating on poor patient outcome events but commissioning investigations to identify learning within the systems under investigation where there may have been no patient harm.
- A follow up visit reviewed our systems in more detail and recognised the work done to ensure a good quality escalation and investigation of adverse events. HIS were impressed by the level of information provided in the quarterly acute and partnership clinical risk reports and with the clinical risk incident management process.

2. Clinical Effectiveness

2.1 NHSGGC Clinical Guideline Framework

Clinical Guidelines uploaded to the Clinical Guideline Directory:

- 339 clinical guidelines have been uploaded to the Clinical Guidelines Directory
 - 105 new clinical guidelines.
 - 83 clinical guidelines migrated from the clinical information site
 - 151 migrated from NHSGGC Staffnet Pages.

Clinical Guideline Review Processes:

- 285 (84%) clinical guidelines are current and valid.
- 48 (14%) clinical guidelines are currently in a review process.

- 6 (2%) clinical guidelines have **breached** their review date and liaison with authors and approval groups are underway to resolve this.

Usage of Clinical Guideline Directory:

- Total No of Hits to Guideline Directory Homepage in March 2016 = 3064
- Total No of Distinct Users in March 2016 = 2000

2.2 Clinical Quality Publications (CQPs)

- 64 CQPs have been identified for tracking since January 2014 to April 2016
 - 52 determined as closed (reviewed by service and any actions considered and agreed)
 - 12 publications are currently under review by services
 - 8 are still within the 6 month timeline for review and response
 - 4 are out with the 6 month time line for review

2.3 Impact Assessment of Clinical Governance Related Publications (publications up to and including January 2016)

Process:

1. All newly published clinical governance related guidance is identified.
2. Sectors, Directorates and Health and Social Care Partnerships are informed and asked to carry out an impact assessment.
3. The outputs of the impact assessment process are then collated using a standard reporting template and tabled at;
 - a. Sectors, Directorates and Partnership/Mental Health Clinical Governance Forums.
 - b. Acute Services Clinical Governance Forum
 - c. Board Clinical Governance Forum

A summary of Scottish Intercollegiate Guidelines Network (SIGN) Guideline 143: Diagnosis and Management of Epilepsy in Adults impact assessment is presented:

- SIGN 143: Diagnosis & Management of Epilepsy in Adults Guideline was published in May 2015.
- The guideline was assessed as having applicability to Regional Services Directorate and the Women and Children's Directorate.
- Impact assessment carried out by identified Consultant medical staff
- The outputs of the impact assessment process were collated and reported to;
 - Regional Services Clinical Governance Forum.
 - Women and Children's Clinical Governance Forum.
 - Acute Services Clinical Governance Forum.
 - Board Clinical Governance Forum.
- The impact assessment highlighted that the majority of recommendations were met with the following identified as areas for further development and improvement.
 - provision of information to pregnant women with epilepsy
 - availability of electroencephalography (EEG) (electrophysiological monitoring method to record electrical activity of the brain) as an emergency intervention.
- The impact assessment process has given the Obstetric Service an opportunity to review and how epilepsy advice is given to pregnant women and for Regional Services to consider the provision of

3. Person Centred Care

The Patient Experience, Public Involvement and Quality Team support three central systems for gathering feedback from patients, carers and members of the public. These are; Universal Feedback; NHSGGC Patient Feedback; and Patient Opinion. In line with our responsibilities under the Patient Rights Act, all of the feedback from these sources is recorded in monthly reports to each Sector/ Directorate and actions taken as a result of this feedback is reported Quarterly.

Universal Feedback

Patients are provided with a card on the day of their discharge asking “How likely are you to recommend this ward to a friend or family member if they needed similar care or treatment?”. A follow up question asks them to give a reason for their response, with the provision of a text box for them to describe their experience. In 2015/16, over 10,000 patients responded with 97% saying that they would be Extremely Likely (84%) or Likely (13%) to Recommend the ward they stayed in. 8890 patients left further comments, 94% of which were positive and mostly related to praise for staff.

NHSGGC Online Feedback

1243 patients, carers or members of the public used the NHSGGC Online Feedback website to give feedback, 44% of which was positive. The biggest proportion of negative feedback from our patients and carers was around Communication, which comprises of issues around active communication with patients and/ or carers with regards to treatment or care plans; a lack of quality communication between staff and their patients and carers; lack of access to information, whether written or oral, from medical and nursing staff; and finally issues with the appointment system. Facilities based issues (e.g. accessibility, parking, smoking or signage and wayfinding) also feature as a theme for improvement.

Patient Opinion

Patient Opinion is another online method of feedback, but one which is run by an external organisation and encourages public dialogue between patients, carers and other service users and the Health Board. In 2015/16, 269 people used Patient Opinion to give feedback on their experience, 48% of which was positive. The negative feedback received reflects that of our own feedback system, with Communication being the key area for improvement highlighted by users of Patient Opinion (as above).

Person Centred Health & Care Team

A small quality improvement team based in the Clinical Governance Support Unit is supporting teams gather feedback and apply the learning through coaching on practical improvements.

Point of Care–Care Experience Feedback using ‘Themed Conversation Approach

The Person Centred Healthcare Team continue to gather and develop care experience feedback on a monthly basis in six clinical teams and provide coaching, mentoring and improvement support to enable them to take forward improvement actions and interventions.

An example of an improvement currently being planned and taken forward in Ward G North at Inverclyde Royal Hospital is to develop a person-centred approach to the ward round in ward G North to improve involvement of patients in decisions about their care; acknowledge their personal needs and preferences and establish consistency and coordination of their care pathway.

Care Experience Pathway Project

Healthcare Improvement Scotland (HIS) supported project to gather care experience feedback across two defined pathways of care has now commenced in both services. Acute Medical Pathway at Glasgow Royal Infirmary and Maternity Pathway at Queen Elizabeth University Hospital and the Royal Alexandra Hospital, Paisley.

4. Clinical Governance System

Key Progress Points on Refresh of Clinical Governance Arrangements following service changes

- Clinical Governance Policy has been mainly completed. There will be proposals presented at the June 2016 board concerning revised arrangements for non-executive oversight. Following this decision, the policy will be amended accordingly and completed
- A standardised Terms of Reference for key clinical governance forums has been developed and is in place for Acute Services. It is being promoted as a reference for HSCPs (who operate joint clinical and care governance forums)
- A planned formal programme of in-depth reviews of clinical governance has been set up for Acute Services Sectors and Directorates
- Clinical Governance reporting requirements at corporate level have been reviewed and reports have been reconfigured with a new overall reporting template for clinical governance being tested
- The role of Quality Improvement leads has been described and promoted with North Sector the first to make an appointment
- Reviews of clinical governance arrangements have been completed with update report be presented to the June 2016 meeting of the Board Clinical Governance Forum
- A clinical quality improvement network has been set up to support training and development on methods, practice and behaviours that enable quality improvement.

5. Quality Improvement

5.1 SPSP Adult Acute

5.1.1 SPSP Deteriorating Patient

Aim:

- 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.

Progress

- The Board is currently meeting national reporting requirements - to report all outcome measures for the work stream; and at least one process measure per core priority area.
- 18% of wards are considered active in Frequency of Observation.
- 5% of wards are considered active in Structured Response.
- 3 teams have reached sustained reliability for frequency of observation ,1 team has reached reliability

Issues

- The measurement of cardiac arrests, the outcome measure associated with the work stream, remains unresolved, and the data set continues to be seen as unreliable. Current mechanisms to improve the reliability of the data have not been successful; and it is proposed that a new system/process for collecting data on cardiac arrests is being considered by the NHSGGC Deteriorating Patient Group.
- NHSGGC is not meeting the goal for process reliability (95%) for compliance with Early Warning Score – current compliance is around 75%.
- NHSGGC is not meeting the goal for process reliability (95%) for compliance with Structured response – current compliance is around 12%.

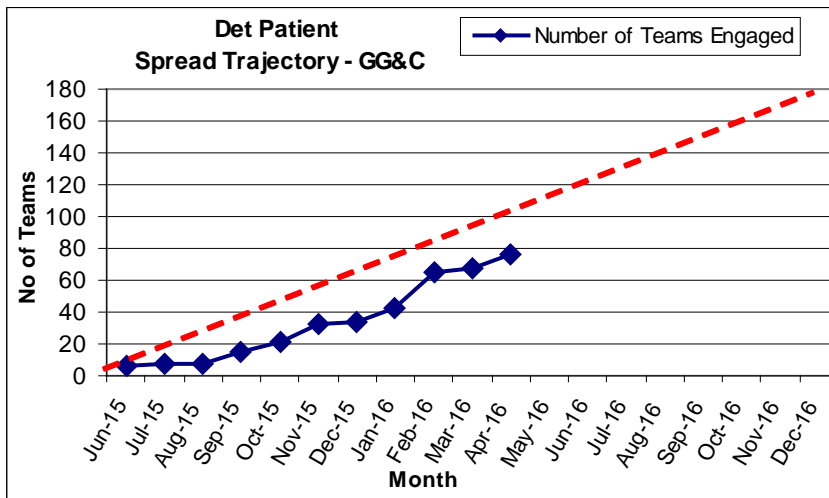
Next steps

- Improving the management of deteriorating patients is a key safety priority for NHS Greater Glasgow and Clyde. A set of development objectives has been established and agreed, and progress will be monitored and reported by the NHSGGC Deteriorating Patient Group.

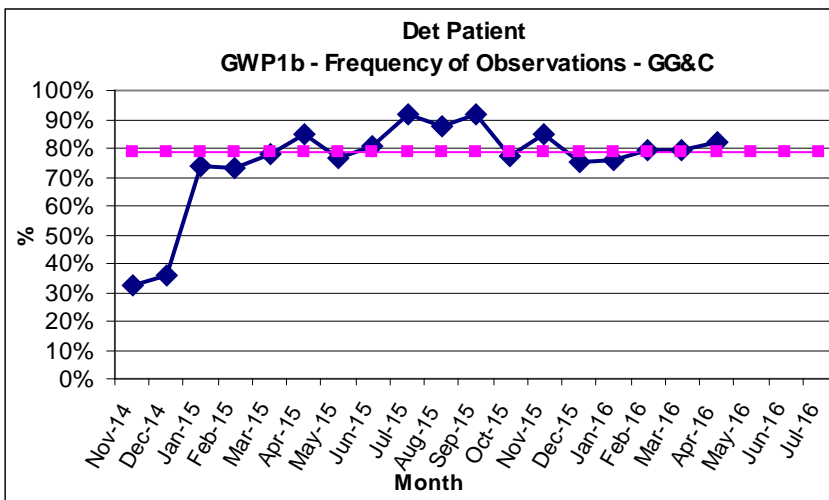
- Aim 1: The ASD sectors and directorates will ensure those wards reporting the greatest frequency of crash calls in each hospital are active in the programme (this will cover those locations reporting 60% of all crash calls by 30 June 2016)
- Aim 2: The ASD sectors will ensure the measurement of the rate of cardiac arrests is provided for each hospital (by 30 June 2016)
- Aim 3: Ensure the wards in this start up cohort are demonstrating a reliable clinical process for early warning score and structured response (by 31 March 2017)

Spread profile

- The work stream is now spreading well and is following the trajectory set, although slightly below target level



Percent compliance with Early Warning Score (correct frequency of observations (goal – process reliability at 95% or greater).



5.1.2 SPSP Sepsis

Aim

- To ensure that all Emergency unscheduled care wards and departments across NHSGGC have a reliable system of sepsis management. In patients with sepsis, the aim is to complete the “Sepsis 6” within 1 hour [Oxygen therapy, intravenous fluids, Blood cultures, intravenous antibiotics, measure lactate & assess urine output].

Progress

- 12 teams are currently measuring compliance, with 7 out of 12 teams submitting data in January 2016.
- Teams are testing the use of stickers and proformas to document process compliance
- 3 teams have achieved sustained reliability and are now on quarterly data return (RAH, VOL, B6WOSCC)

Issues

- Still no electronic solution to ease the burden of data collection for front line teams. TRAK was engaged with the Emergency Department team at QEUH but this work has stalled and this has been escalated to the recently appointed consultant e-health lead. A formal proposal for this has to be developed and presented for consideration.

Next steps

- Ensure the emergency departments and admission/assessment wards are able to demonstrate a reliable clinical process for Sepsis six (by 31 December 2016) (estimated target of 20 wards)

5.1.3 SPSP Venous Thromboembolism Prevention

Aim

- To improve delivery of risk assessment and appropriate treatment to reduce harm and mortality from venous thromboembolism.

Progress

- 27 wards confirmed into the programme across the Acute Services Division (adult wards).
- A further 9 wards are in the process of recruiting to the improvement programme in April 2016.
- There is an increased confidence in the changes tried and tested in the 7 wards which have demonstrated sustained reliability, and are at present transitioning from the testing and measurement model of support to an implementation approach.
- Sustained Reliable (9 or more data points currently with a median of $\geq 95\%$).
 - 7 wards have demonstrated sustained reliability for all measures

Issues

- The scope and scale of the Acute Services Division to which this improvement programme is applicable is a challenge in itself with regards to spread. In addition, the other priority areas for improvement, e.g. deteriorating patient, medicine reconciliation and sepsis make the improvement landscape with regards to spread particularly challenging for clinical teams, managers and improvement support, as all of these work streams have a particular focus on front door admission areas.

Next steps

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

5.1.4 Medicines Reconciliation

Aim

- The process that the healthcare team undertakes to ensure that the list of medications a patient is taking matches the list held by General Practitioners (GPs), hospital teams and community pharmacy. The focus is on transitions of care, specifically admission to hospital and discharge back to primary care. Medicines reconciliation on admission to hospital involves the prescriber finding out what medicines the patient was taking prior to admission, deciding whether each medicine is appropriate given their current condition, and documenting a plan for each medicine (continue/withhold/stop). Medicines reconciliation at discharge involves the prescriber reviewing current medication to decide what has changed/stopped since the patient was admitted and what should be continued post discharge. This information is then communicated to primary care in the Immediate Discharge Letter (IDL).

Progress

- The primary focus to date has been improving medicines reconciliation (MR) on admission to Hospital. 45% of wards, which admit in-patients, are engaged in this workstream, including all receiving units. Current measures show between 50-60% of patients have MR documented within 24hrs of admission and 80-85% of patients have an accurate prescription chart within 24hrs of admission. In preparation for focusing on MR at discharge, GP practices across NHSGGC collected data on Immediate Discharge Letter (IDL) they received, and reported that 80-90% of IDLs, from across all acute hospitals, have a satisfactory level of information about medicines and changes made during the patient's stay. The Acute Services Division has agreed the following three objectives for 2016/17:
 - Ensure all clinical teams currently engaged in the workstream demonstrate a reliable medicines reconciliation process and accurate prescription chart within 24hrs of admission (by 31 March 2017)
 - Ensure there is a spread plan that means all target clinical teams are actively engaged in the workstream to improve medicines reconciliation within 24hrs of admission (by 31 December 2016)
 - Ensure there is a plan that means 50% of clinical teams are actively engaged in improving medicines reconciliation at discharge (by 31 December 2016)

Issues

- Many areas have demonstrated the capability to do medicines reconciliation well, but struggle to maintain a high level of reliability over time. This can be attributed to reliance on junior doctors who regularly rotate and that medicines reconciliation takes time to do properly, so busy receiving units, with a high patient throughput, can struggle when busy and juggling competing priorities.
- Acute service re-organisation, notably the move to the new hospital disrupted engagement with the programme, but this is being addressed with newly engaged teams and leads in place in Queen Elizabeth University Hospital.
- It is recognised that Sectors/Directorates need to take greater ownership of the workstream and ensure they have the appropriate infrastructure in place to deliver and monitor performance against the programme objectives.
- The current Medicines Reconciliation eForm is to be replaced by a new Medicines Management application in the clinical portal, which has enhanced functionality. This application will support Medicines Reconciliation on admission to hospital with an interface to the Emergency Care Summary. The list of reconciled medicines will then be used as the starting point to review medicines at discharge and produce the Immediate Discharge Letter. This will create a joined up reconciliation process from admission to discharge with reduced transcription. The application is being developed to meet NHSGGC specification and will be available for testing in September 2016.

Next steps

- In response to the challenges faced in the programme there has been renewed efforts to ensure Sectors & Directorates take ownership of the work and develop implementation plans to deliver the

agreed objectives for 2016/17. They are supported in this by Pharmacy and Prescribing Support Medicines Governance Leads, who are working with Chiefs of Medicine, nursing and pharmacy to ensure all engaged teams have identifiable medical, nursing and pharmacy leads and senior managers with responsibility for performance and reporting through governance pathways. Teams are being asked to review their current Medicines Reconciliation process, test improvement ideas and measure the outcomes.

5.1.5 Falls

Aim

- The national aim is for a 25% reduction in the number of falls by December 2015 and a 20% reduction in the number of falls with harm by December 2016.
- The overarching aim of the Falls bundle is to achieve a reduction in the number of falls whilst promoting recovery, independence and rehabilitation.

Progress

- The Prevention and Management of Falls Policy was ratified at the Board Clinical Governance Forum. A yearly review is planned to commence in August 2016.
- A Prevention and Management of Falls Guideline has undergone consultation and has been updated. This compliments the Falls Policy.
- A LearnPro module is also currently under construction. These supporting documents and education module complement each other and include the elements of the safety bundles.
- Elements of the falls bundles are also elements of Care and Assurance Standard (CAS) Standard 2. The one page double sided risk assessment and intervention plan that has been developed encompasses safety bundles 1-3 and evidences 9 elements of the CAS standard. All link nurses will attend education involving all elements of the bundles and the CAS elements therefore empowering them to 'coach' colleagues within the ward.

Issues

- The Falls Scottish Patient Safety Programme (SPSP) is not supported at ward level by a dedicated improvement advisor, however the falls co-ordinators provide a coaching methodology to the test wards. The introduction of Link Nurses within clinical areas to support the roll out of the Falls CAS standard over the coming year will further support the coaching methodology. Data is currently collected manually and entered onto an Excel Spreadsheet. An IT solution is currently being explored.
- Spread of the bundle documentation at operational level is currently under discussion by the Falls Service Lead, Practice Development and the Quality and Assurance Directorate and bundles are currently under review.
- Test / pilot areas continue to use the falls bundles.

Next steps

- To continue to review and plan the roll out of risk assessment documentation to replace Cannard. Cannard risk assessment tool will be withdrawn, and replaced by the Scottish Patient Safety Programme (SPSP) risk assessment and interventional plan (which includes the interventions for bundles 1-3) as bundles are rolled out.
- Bundles 1-3 documentation is under review by the inpatient falls group. Bundles 1 – 3 use continues in test / pilot areas. Plan is to roll out Bundles 1 -3 following review commencing August 2016

- All wards can monitor the number of falls via Datix reports. These reports will become more refined as the Care Assurance Dashboard project progresses.

5.1.6 Tissue Viability

Aim

- The national aim for reporting pressure ulcers is zero pressure ulcers or 300 days between hospital acquired pressure ulcers (grade 2-4) per ward or department by the end of December 2016.

Progress

- Elements of the pressure ulcer bundle are also elements of Care and Assurance Standard (CAS) Standard 1. The one page double sided (risk assessment and intervention plan that has been developed to replace Waterlow (Pressure Ulcer Daily Risk Assessment (PUDRA)) encompasses the bundle elements and evidences 8 elements of the CAS standard. All link nurses will attend education involving all elements of the bundles and the CAS elements therefore empowering them to 'coach' colleagues within the ward.
- Spread of the pressure ulcer risk assessment and interventional plan commenced in South Sector on 18th January 2016 and has now been successfully implemented across all sectors.
- The process measures for Tissue Viability have recently been reviewed with the Programme Manager and supporting governance structures. The measure has been and is defined as: Percentage compliance with pressure ulcer prevention risk assessment (for all patients) which includes skin condition assessment documented, within 6 hours of admission or transfer to this care area using a risk assessment tool.

Issues

- The Pressure Ulcer Scottish Patient Safety Programme (SPSP) is not supported at ward level by a dedicated improvement advisor, however the tissue viability nurses provide a coaching methodology to the test wards. The introduction of Link Nurses within clinical areas to support the roll out of the Pressure Ulcer CAS standard over the coming year will further support the coaching methodology. Education / training is being prepared for these Link Nurses.
- Data is currently collected manually and entered onto an Excel Spreadsheet. An IT solution is currently being explored. National Standards for Pressure Ulcer prevention and management are currently out for consultation by Healthcare Improvement Scotland (HIS). Whilst the consultation version draws on NHSGCC current practice, there is a minimal risk the final version (due for publication later this year) may have an impact for changing current practice.

Next steps

- Roll out of an evaluation of PUDRA documentation and usage is currently in progress, and being undertaken by the Tissue Viability Service, across all sites. Results from early implementer sites identify compliance with the use of the document with a potential reduction in acquired pressure damage. Analysis of data will be complete by the autumn.

5.1.7 Catheter Associated Urinary Tract Infection (CAUTI)

Aim

- To achieve 95% or greater compliance with NHSGCC Adult Urethral Urinary Catheter (AUC) Insertion and Maintenance Care Plan.
- All patients with a urethral urinary catheter should have an NHSGCC Adult Urethral Urinary Catheter (AUC) Insertion and Maintenance Care Plan to evidence optimal care of this invasive device.
- Reduce Catheter Associated Urinary Tract Infections.

Progress

- Successful roll-out of NHSGCC AUC Insertion and maintenance care plan

- Catheter Associated Urinary Tract Infection (CAUTI) process and outcome data is being measured across 8 sites in NHSGGC to date: GGH, IRH, Vale of Leven, RAH, Stobhill, Lightburn, QEUH (SIU and INS) and the GRI.
- 203 wards in total are engaged in the CAUTI work stream with 184 submitting data to the Quality Improvement Facilitators (QIFs) for April 2016. Data is now submitted to and managed by the local management system.
- Bladder Scanner: A snapshot survey of Bladder scanner use and availability over one day was undertaken and findings reported at the Acute Clinical Governance Forum meeting on 16th November 2015. Wards without access to bladder scanners were identified and highlighted to Directors. A more extensive report was submitted in March 2016 identifying full results for Sectors. Responsibility for review of access to bladder scanners is through the senior management teams.
- Care and Assurance Standards (CAS): The Quality Improvement Facilitators (QIFs) have commenced a second work stream to support the Acute Service CAS CAUTI standard roll out in wards which are developing CAUTI link nurses. A series of Web-Ex have been successfully provided to link nurses across the whole of NHSGGC.

Issues

- Funding and support for this work stream was provided from Health Improvement Scotland for two years and has now come to an end. The two Quality Improvement Facilitators (QIFs) were in post until the 24th May 2016.
- Large amounts of data were submitted by wards to the Quality Improvement Facilitators (QIFs) who undertake quality assurance prior to reporting. This was undertaken manually. There is no IT solution currently available for Senior Charge Nurses (SCNs) to submit their data.

Next steps

- A large number of teams are now engaged in collecting quality improvement data for CAUTI. We require to identify a process for data collection, analysis and reporting.
- Requirement to establish if CAUTI remains a prioritised safety priority.

5.2.1 Paediatric

Progress

- The Paediatric Intensive Care Unit has sustained reliability in Ventilator Associated Pneumonia (VAP) and Central Line processes with a reduction in infections (outcome data) also evident.

Issues

- Data collection has been an issue and is currently being addressed within the service.

Next steps

- NHSGGC's current focus is on Peripheral Venous Cannula and Central Venous Cannula bundles. The central line insertion work is spreading formally to theatres who are currently testing, the maintenance process has now spread to 8 wards.
- New priority areas have been announced by the national team with a focus on medication errors and deterioration in paediatrics. Units will be supported in the implementation of these measures as soon as the details are available.
- Nationally the focus is on medication safety currently which is being progressed by pharmacy, and for 2017 the paediatric deterioration bundle will be focus, and the bundle is at planning stages in NHSGGC.

5.2.2 Neonates

Progress

- Princess Royal Maternity (PRM) are measuring in seven areas. They are stepped down for one measure, demonstrating sustained reliability for two measures and capability with four measures.

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

Issues

- Within neonates all units are reporting a reliable process in relation to central line maintenance however the outcome measures show that there a small but continued incidence of staphylococcus aureus bacteraemia (SAB) in neonatal units. There is an established working group reviewing contributory factors and additional preventative measures.

Next steps

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

5.3 SPSP Mental Health

Progress

- During 2015/16 a scoring system was introduced across the fourteen wards to ascertain what level of support was required across the wards.
- Leadership and Culture: All 14 wards have had Safety Conversations (SC) carried out in 2015. The actions are discussed at the Scottish Patient Safety Programme for Mental Health Steering Group on a regular basis. 30 actions have been identified from the 2015 SCs, of which 29 have been completed to date. All wards are participating in the staff and patient safety climate surveys.
- Risk Assessment: The risk assessment bundle has been updated in line with feedback from the 14 wards that were testing. The bundle has now been agreed and compliance has increased from 43% to 65%.
- Communication at Transition: A new bundle has been developed to check if patients are followed up within 7 days of discharge from hospital. Early results suggest that the definitions need more work. A video has been filmed for the wards to see an example of a Safety Huddle.
- Restraint: A bundle has now been developed for Restraint but will be tested in four of the fourteen wards. The bundle will ensure that a person centred care plan is in place and that should restraint occur that a debrief takes place.
- Safer Medicines: Safer Medicines included a sticker for wards to use in patients notes to highlight the use of 'as required' medication. All 14 wards are using these stickers and find them helpful. A bundle has now been developed to ensure that the 'as required' stickers are discussed at the multi disciplinary team meeting and changes to medications considered where necessary.

Issues

- Data collection: The data collection tools are developed in house by clinical governance staff. The next step will be to roll out bundles to community teams, older peoples teams, perinatal and children and adolescent mental health teams. This will require an electronic solution to data collection.
- Definitions: It has become evident whilst testing bundles that definitions should be more explicit e.g. the wards are asked to record whether the patient was seen within 7 days and they are recording yes if the patient is given an appointment as opposed to whether the patient was seen.

Next steps

- An implementation plan for spread across Mental Health Services will be discussed at the next Steering Group.

5.4 SPSP Primary Care (PC)

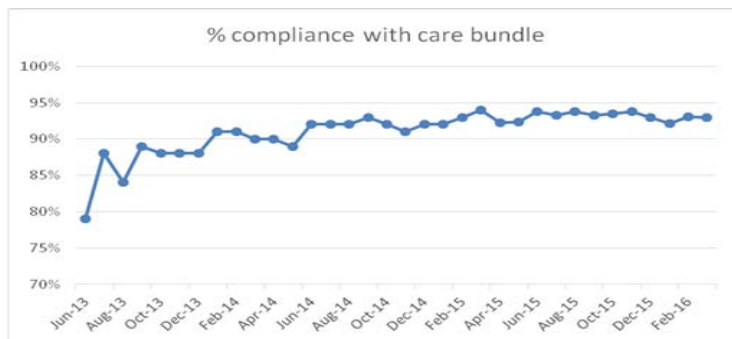
Aim

- The aim of the Scottish Patient Safety Programme in Primary Care is to reduce the number of events which could cause avoidable harm from healthcare delivered in any primary care setting. Within 2015-2016 there have been a range of workstreams which contribute to improving safety within the setting. The work is supported by clinicians and staff from the Clinical Governance Support Unit (CGSU). These workstreams are described below and provide update on progress, issues and the next steps.

5.4.1 Medicines Reconciliation (PC)

Progress

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



Issues

- Data collation has been an on-going challenge.

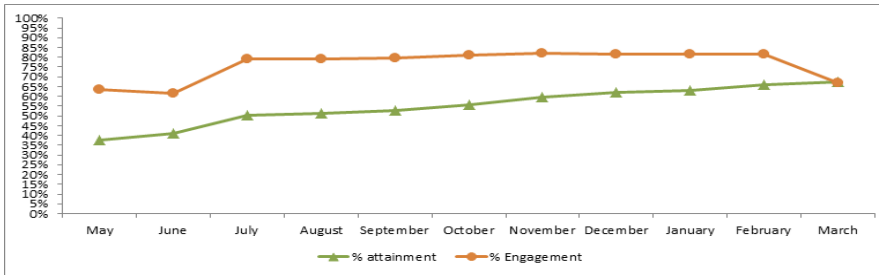
Next steps

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

5.4.2 DMARDs (Disease-modifying anti-rheumatic drugs)(PC)

Progress

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



Issues

- Some initial IT issues resolved quickly and data collection tool installed. Road shows at start of LES, telephone and or 1:1 visits have improved understanding and uptake. Improvements have been seen in processes of care being delivered at practice level, enhancement of patient safety and in clinical outcomes. Examples of best practice has been shared in order to reflect and promote change with all members of practice teams.

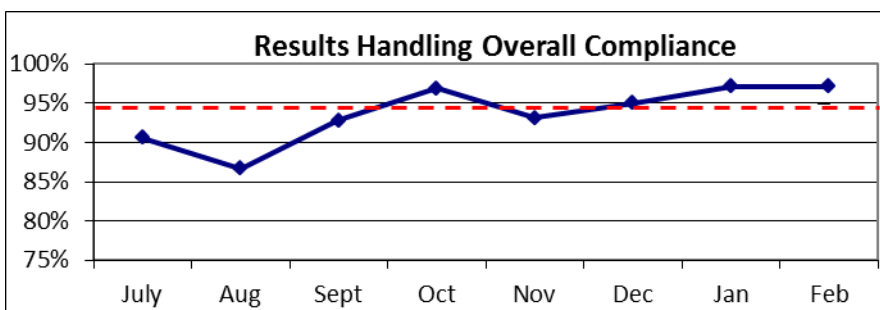
Next steps

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

5.4.3 Results Handling (PC)

Progress

- In a review of Significant Event Analyses (SEA) in general practice in Scotland (2009) 20% of SEAs related to results handling systems. In November 2013 a new results handling bundle was developed by NHSGGC and NHS Grampian. This has now been adopted nationally by Healthcare Improvement Scotland (HIS) and rolled out to all other boards. In NHSGGC during 2015/16, 9 GP Practices have been involved in the Results Handling work. There has been significant improvement in compliance since the original Nov 2013 bundle, when compliance averaged at 60% across the participating practices. The chart below highlights compliance form July 2015 to Feb 2016.



Issues

- The 9 practices involved have demonstrated strong compliance to using the bundle. They report that this has resulted in more reliable systems, valuable team discussion about communication of results, identified interface issues with the labs and improved confidence with GP reception staff to report issues with the handling of patient results.

Next Steps

- The introduction of 'Ordercomms' has assisted with the significant improvement with compliance. This electronic IT system enables patient information and test results to be shared more smoothly and quickly between GP Practices and Hospital Services as they both have access to the one system. There is confidence that this will be in place for all GP practices in NHSGGC. Given the

positive results and the reliable IT system it has been agreed that the results handing workstream will not continue in 2016/17.

5.4.4 CAUTI/ MUST (PC)

Progress

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

Issues

- While the IT dashboard is in place for MUST further work is required to the system to produce more detailed local reports. There is a need for the CAUTI bundle to be placed onto the IT system so information can be stored and collected.

Next steps

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

5.4.5 Sepsis (PC)

Progress

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

Element	Criterion	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
NEWS Score	Was a NEWS score carried out?	100%	100%	100%	100%	100%
Antibiotics considered	Were antibiotics considered as per NHS GGC prescribing guidelines?	100%	100%	100%	100%	100%
Ambulance priority	Was the most appropriate priority ambulance ordered?	100%	84%	100%	100%	89%
Communication of NEWS	Was the NEWS score communicated to the admitting hospital?	100%	95%	100%	50%	78%
Diagnosis Documented	Was the diagnosis documented?	100%	95%	100%	100%	89%
Overall Compliance with Bundle	Have all elements of the bundle been met?	100%	74%	100%	50%	78%

Issues

- Using the NEWS has demonstrated consistency and measurement of key clinical variables. There is positive feedback from GPs.

Next steps

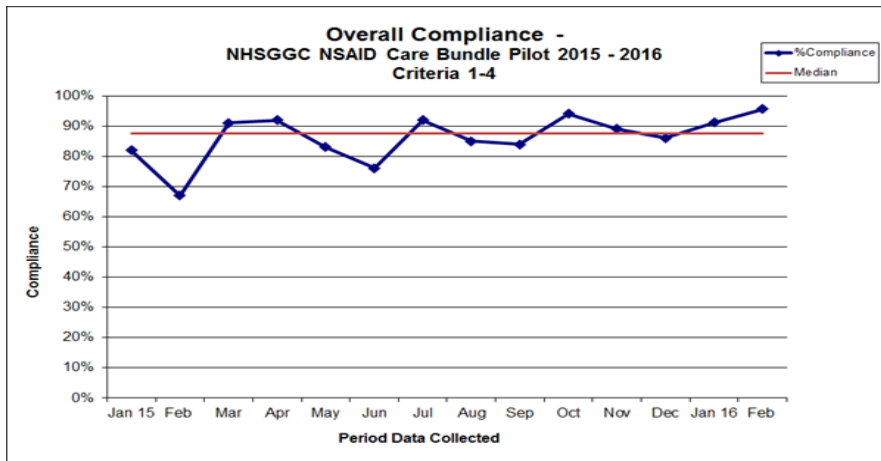
- The GP's are planning to develop patient case stories to use within learning sessions, to provide a patient focused dimension to the programme. Plans to have future learning sessions and involve

more GP's this year is underway. The feasibility of adapting the Out of Hours IT System (known as Adastra) to improve the recording of Sepsis and the NEWS observations is being discussed.

5.4.6 High Risk Medicines (PC)

Progress

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



Issues

- Key successes have been made with bundle compliance. We are now receiving feedback on the “softer” elements of the programme with the pharmacy teams feeling more involved in clinical care, being part of the follow up and seeing their recommendations being implemented. Development for direct access to Clinical Portal is underway and will assist in a smoother transition between services.

Next steps

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

5.4.7 Asthma (PC)

Progress

- Supporting 5 pilot GP practices submitting care bundle data monthly. 1 practice had staffing issues and provided inconsistent monthly submissions. Improvement has been seen around use of Asthma

Management Plans, improving teamwork, communication and also reviewing asthma diagnosis to allowed practices to target non attendees.

Issues

- Guidance documents and data collection tool provided to practices. Changes made to the bundle after 3 months to allow for passive smoking to be addressed also. Best practice shared in order to promote safe asthma care.

Next steps

- As of 31/3/2016 2 practices have shown an interest in continuing with Asthma bundle. Broader discussion with SPSP Primary Care Steering group required to discuss next steps.

6. Training and education for clinical quality

6.1 Developing Quality Improvement (QI) Capability

- 15 clinical staff in NHSGGC have completed the Scottish Patient Safety Fellowship Programme
- 3 staff in NHSGGC have completed the Scottish Improvement Leadership Programme (SciL) and a further 2 are part way through the programme.
- 9 staff in NHSGGC have completed the Institute for Healthcare Improvement Advisors (IA) Development Programme
- 323 staff have attended 11 one day Quality Improvement Workshops held over the past 18 months
- Quality Improvement workshop for pharmacy staff took place on 20th April 2016
- Quality Improvement workshop for Mental Health took place on 28 April 2016
- Quality Improvement workshop for Clinical Leaders took place on the 3rd May and the 2nd June 2016, and a further two sessions are planned for later in the year
- Quality Improvement workshop for Partnership staff took place on 31st May 2016
- Allied Health Professionals Quality Improvement Development Programme is in the early stages of discussion with the Director for Allied Health Professionals.

6.2 Root Cause Analysis Training

(Root cause analysis (RCA) is a method of problem solving used for identifying the root causes of faults or problems)

- In the last 3 years there have been **390** staff in Acute and **211** staff in Partnerships (601 total) trained in Significant Clinical Incident process and root cause analysis investigation. In the last 2 years this has also included an increased focus on human factors.
- Training continues to be offered with courses planned for this year. Many other Scottish Boards are not able to provide this training internally and require to send staff to external training or contract trainers to provide this for their organisation.

7. Information and IT

7.1 Care Assurance Quality Dashboard

Aim

To have real time data readily available in an electronic format in order to report and monitor nursing clinical quality indicators. A Care Assurance Quality Dashboard is currently being developed to record and display quality measures at ward / clinical area level. Data items should be recorded once by front line staff, and shared many times in a variety of electronic reporting formats at varying levels within and outwith the organisation. In addition much of this information should be displayed at ward level for the public to view. This information can be viewed via an electronic dashboard showing key care assurance (quality) indicators. The Dashboard is multidisciplinary and as development progresses it is envisaged that other

quality indicators and outcomes will be included. This may vary from ward to ward, although all wards will have a common core data set.

Progress

At present data items are stored in many places and many systems requiring manual resource to collect, collate and report. The development of an electronic dashboard approach will bring together agreed data sets in order that outcomes can be viewed as proxy measures of quality and care assurance.

Data will be viewed at:

- ward level
- area level
- hospital
- board level.

Metrics within the dashboard will vary as they move up the levels of reporting. It is planned to develop the electronic dashboard in a phased approach.

Next Steps

- Initial scoping underway. A full project initiation document is being developed and will be presented in the first instance to the Strategic eHealth Group.
- By the end of June 2016 the content and data sources for the dashboard will be scoped out to ensure that relevant and appropriate information is collated. It is anticipated that a simple dashboard will be developed by the end of August 2016 and that this will contain existing metrics that are available from current electronic systems. It is also anticipated that by the end of October 2016 that a data repository will have been developed, tested and implemented for current nursing quality indicators that are identified within the Care Assurance Standards.
- It is anticipated that the dashboard will become multidisciplinary with initial plans for medical quality indicators to be included and to align NHS HIS Design Panel recommendations on quality indicators.

7.2 Clinical Indicators Project

Aim:

- To develop overall clinical indicator set(s); by nominating and presenting an “indicator of the week” and testing response.

Progress

- Log of 11 proposed indicators created (up to 14/03/2016)
- Development of draft reports for indicators, and some testing with clinical services is underway

Issues

- Clarifying infrastructure and process
- Further indicators to be proposed.

Next steps

- Weekly meetings of project group to be established to review draft indicator of the week
- Create template for review of each indicator

7.3 Morbidity and Mortality (M&M) Improvement Project

Aim

- Enhance the effectiveness of Morbidity and Mortality reviews to improve patient safety.

Progress

- 4 pilot teams established who are testing all elements of the project.
- The Datix PALS (Patient Advisory and Liaison Service) module has a flexible interface that can be modified to support the collection of additional information. The NHSGGC Datix Team have been able to adapt this module for use during Morbidity and Mortality (M&M) review meetings to enable clinicians to gather their M&M data electronically allowing it to be fully analysed.
- The first pilot team utilising the Datix M&M Pals form is the Vascular pilot team at the Queen Elizabeth University Hospital.
- A Guidance document has been developed and tested with all pilot teams to highlight what a “gold standard” approach to Morbidity and Mortality reviews would include.
- An electronic Chair checklist has been developed and disseminated to clinical teams for completion. Reporting measures will highlight any areas for clinical teams to approve upon supported by the Morbidity and Mortality Project Lead.
- A poster on Enhancing the Effectiveness of Morbidity and Mortality Reviews to Improve Patient Safety was accepted and presented at the recent NHS Scotland Event 2016. Please click [here](#) to see the poster.

Issues

- Dependant on clinician time project timescales may slip however continual communication and support to teams can bring the project back on track.
- Other clinical teams are eager to engage however resources to support the Datix element need considered and clear project timescales and engagement is necessary to ensure any other clinical teams are supported timely.

Next steps

- Support Clinical teams to progress gaps/actions that have been identified from the stakeholder surveys.
- Developing Datix M&M form for other specialties and capturing their reporting requirements
- Utilise the action module within the Datix Pals Module to capture meeting actions internally with the department then to further explore adding stakeholders within other clinical teams