NHS Greater Glasgow & Clyde

NHS Board Meeting **17 October 2017**

Medical Director/Nurse Director **Paper No: 17/57**

Clinical & Care Governance Report

Recommendation:-

The NHS Board is asked to:

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

Purpose of Paper:-

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

Key Issues to be considered:-

This report focuses on an overview of

- Progress in implementing Duty of Candour
- SPSP Acute Adult Work-stream
- NHS GG&C response to the HIS report on Maternity Service in Ayrshire and Arran

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

The supporting objective:

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

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Greater Glasgow and Clyde NHS Board

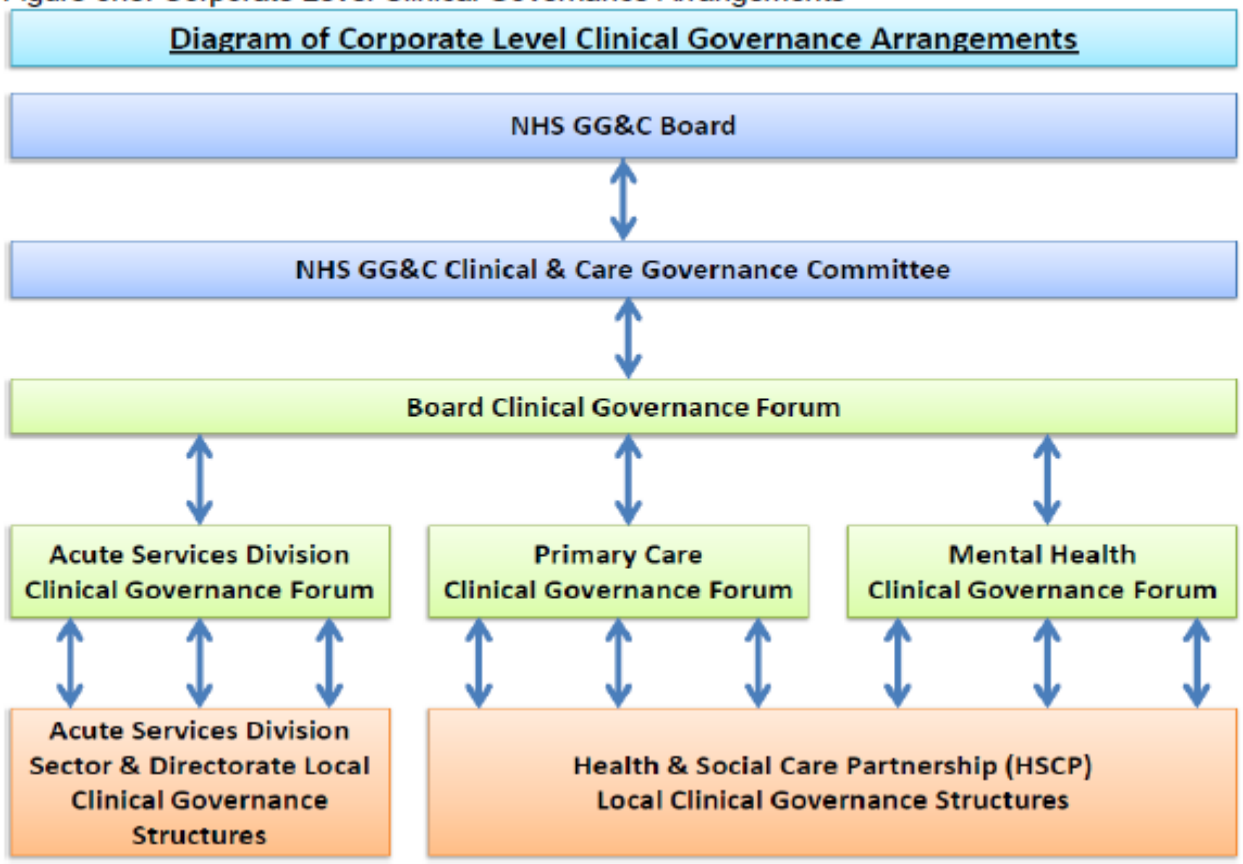
CLINICAL AND CARE GOVERNANCE REPORT (up to October 2017)

Introduction

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

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

Figure one: Corporate Level Clinical Governance Arrangements



It should be noted there is a large range of more detailed reports being reviewed in the local clinical governance forums. These are collectively structured around the main domains of clinical quality and governance, set out in NHS Scotland National Quality Strategy, as follows:

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

This report has been developed to provide the NHS Board with a short, illustrative summary of clinical governance. This report is limited to a description of key points on progress and challenges arising from a sub-set of more extensive activities across the clinical governance arrangements. The content will reflect the more direct oversight roles of the Board Clinical Governance Forum and of the Clinical and Care Governance Committee.

This report focuses on an overview of

- Progress in implementing Duty of Candour
- SPSP Acute Adult Work-stream
- Response to the HIS report on Maternity Service in Ayrshire and Arran

The Board of NHSGGC is asked to;

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

1. Corporate Objectives

The clinical governance arrangements have responded to the Chief Executive direction "that these organisational objectives provide a focus for wider engagement". There are a number of corporate objectives that relate to clinical quality and governance. This report provides an update on two of the key areas. These are;

- Establish a Duty of Candour Policy and Implementation Plan for the NHS Board
- Further develop Scottish Patient Safety Programme (SPSP) initiatives with clear action plans and ensure appropriate reporting to the NHS Board.

1a. Duty of Candour

The Board members have previously been advised that the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 introduced a new organisational duty of candour on health, care and social work services. The implementation date for the duty of candour to come into effect is 1 April 2018.

The overall purpose of the new duty is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm, as defined in the Act. This duty requires organisations to follow a duty of candour procedure which will include notifying the person affected, apologising and offering a meeting to give an account of what happened. The procedure will also require the organisation to review each incident and offer support to those affected (people who deliver and receive care).

NHS GG&C have maintained a requirement of being open within the Significant Clinical Incident Policy, with associated monitoring, for some time. The Board performance on being open has been steadily increasing over recent years as staff build confidence in engaging with patients in often difficult circumstances. We are now able to show that in more than 80% of incidents those affected are advised of the adverse event and of our intention to conduct a review. This ensures that the patient can contribute to the review process and receive the final report if they so desire. In the other instances, where it is deemed inadvisable to inform, the reason for this decision is recorded and verified. Anticipating the duty of candour requirements we have recently instituted a change in practice requiring senior review and confirmation of any decision not to inform.

As a result of our long term commitment to being open staff in NHS GG&C have been commended by the national leads for their knowledge and experience, and have been actively involved in the national implementation structure. This includes the development of training resources, which are being promoted by NHS Education Scotland, and input to the development of the national regulations and guidance. We are also hosting a visit from the new Head of Learning and Openness, Scottish

Government, on 6th October to showcase the way our current systems operate and the develop plans to meet the duty of candour in full.

Scottish Government have advised the details will be set out in Regulations which will be published prior to 1st April 2018. These were initially expected to be published in early October to allow time for the development of more specific guidance. In spite of the delay the Board is still expected to meet the duty when it comes into to force in April 2018.

The local implementation group has now been set up to oversee this work, which includes representatives from a broad range of services. The group has met twice and agreed on the need for a specific policy to be published. A draft policy document is currently being prepared for consultation. Staff awareness has stimulated through presentations and communications, including the core brief and Staffnews. A staff training module, to develop skills in communicating sensitively at the time of a harmful event, has been piloted. The Board is well placed to meet the Duty of Candour regulations when they come into place in April 2018.

1b. Scottish Patient Safety Programme (Acute Adult Workstream)

There are four programmes areas in SPSP;

- Acute Adult
- Mental Health
- Primary Care
- MCQIC (for Maternity, Paediatric and Neonatal services)

The reports of the Acute Adult work-streams have recently been reviewed through clinical governance forums and a summary is presented here.

Deteriorating Patient

There has been a ongoing challenge in the measurement of cardiac arrests, the outcome measure for this work stream. The varaiblity in data quality means aggregated acute data is generally unrelaible. In April 2017, the Acute Services Division Clinical Governance Forum agreed a proposal that all cardiac arrests should be considered clinical incidents, with all emergency calls realting to cardica arrest recorded on DATIX. A short life working group was commissioned to progress this approach. The group has now reached a conclusion and a set of proposals has been agreed and is being taken to the Datix team for implementation. This new process will facilitate the identificaion and review of care for all patients experiencing a cardiac arrest. The review will support confirmation of the quality of care preceding any arrest and provide opportnuties for educational based feedabck to clinical teams.

The improvement approach for preventing patient deterioration is based on detection of risk through the Early Warning Score (EWS) then clear management of risk through the

structured response bundle. Nursing teams have made good progress in developing models of reliable use of EWS. However the strucured response bundle is proving to be overly complicated and difficult to consistently measure, so the quallity of clinical care is often underrecognised. The Aute Services Division Clinical Governance Forum has therfore endorsed the development of an NHS Greater Glasgow and Clyde Structured Response bundle and measurement system, and commissioned a short life working group to conclude the redevelopment of the bundle. This work is nearing conclusion and a final model is being consulted on with services. The design has been well recieved by clinicians and positivley consdiered by national leads.

Sepsis

There has been a steady improvement in delivering the first antibiotic within an hour in patients with severe Sepsis. The current relaibility levels for teams working to improve is currnetly reported at 85% (Please note: some teams have achived required levels and are no longer reporting). The burden of data collection is a challenge for all clinical teams. The proposal to reduce data collection was considered in September. We have been able to demonstrate that a focus on one safety critical measure (the 'time to first anti-biotic') provides an adequate insight into the quality of the care process. We have now been able to endorse a simplified approach which is based on this single measure, which will be implemented in coming months

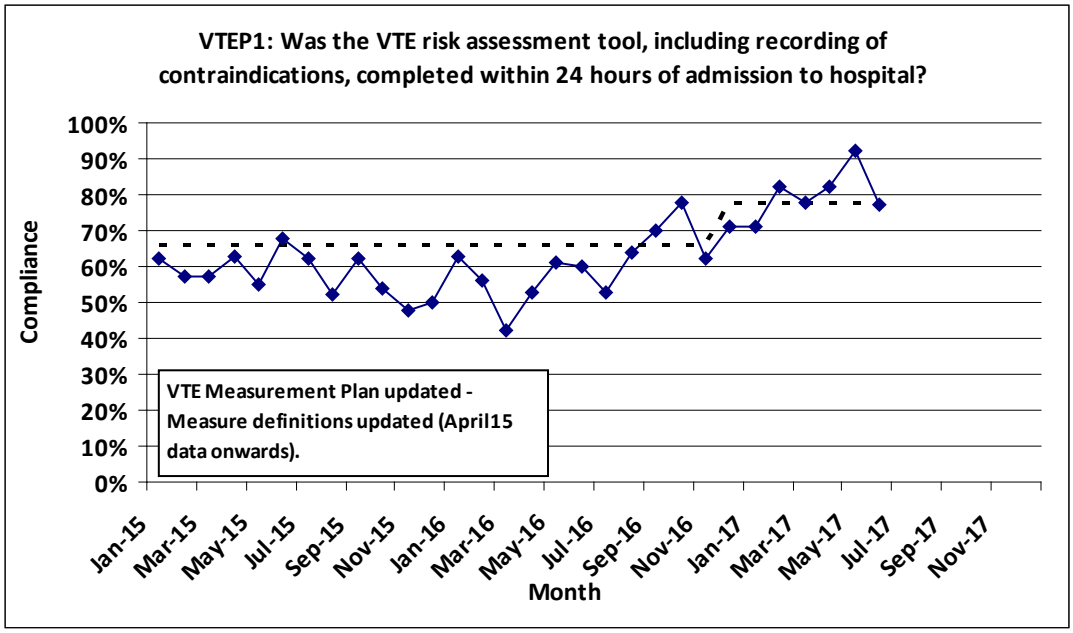
Medicines Reconciliation

The focus of the programme is to maintain the current level of engagement whilst continuing to encourage and support teams to make improvements. However the challenge of completing the documentation has been well described as a blockage to complete implementation. The main focus is therefore the implementation of the new Orion medicines module in clinical portal to enable improved performance. A delivery plan is in development to ensure roll out commences in autumn 2017. This involves reinforcing training on the medicines reconciliation process integrated within use of new the application. This will be systematically delivered to all wards across the acute division. The application will also remove the need for manual data collection to measure completion of the medicines reconciliation process, although manual data collection will remain to confirm accuracy of the prescription kardex.

Effective Medicines Reconciliation is an essential component of clinical governance, ensuring patient safety through the safe and appropriate use of medicines in each individual patient. It is a basic principle of good medicines management and is underpinned by good prescribing practice and communication at the interfaces of care. The process involves establishing and maintaining an accurate, up to date list of medicines and details of changes from admission, through transfer and at discharge back to primary care. Poor medicines reconciliation processes lead to medication errors, patient harm, longer stays and re-admissions.

Venous Thromboembolism (VTE)

38 wards are engaged currently in the work stream, with 11 wards reaching targeted level of sustained reliability for a documented risk assessment within 24 hours (see chart). The priority areas for improvement, e.g. deteriorating patient, medicine reconciliation and sepsis all have a particular focus on front door admission areas, which are the focus of other programmes. The Acute Services Division has noted this challenge and asked for clarification on the spread plan for each Sector and Directorate.



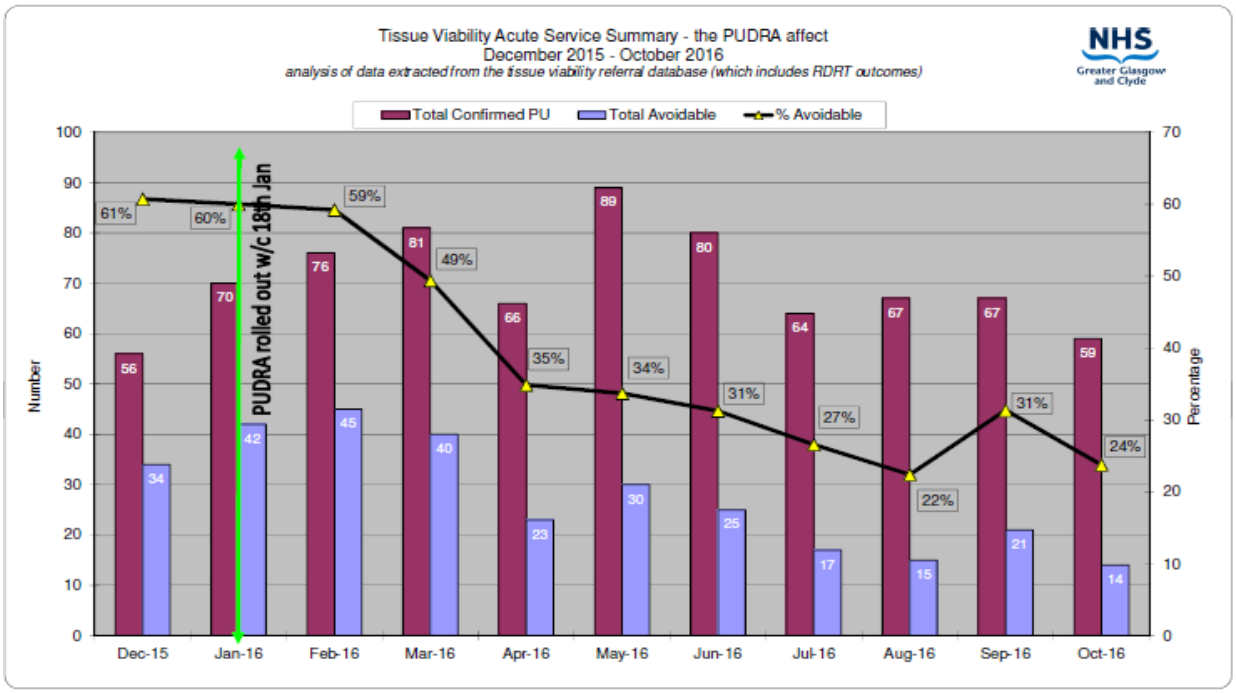
Falls

The SPSP falls safety bundles have been implemented across all NHSGGC acute inpatient sites. Checking audits are being carried out to confirm the maintance of good practice. The most recent round of audits, carried out in January and July 2017, demonstrate a consistant high level of compliance (97%) in the use of the bundles in the Clyde Sector. The Acute Services Division has noted there is a much broader programme of support and improvement than is apparent from SPSP. It was acknowledged that SPSP can be a minor part of the improvement programme and new initiatives such as Excellence in Care provide additional support to quality management. The Head of Clinical Governance has since met with the coprorate lead for Falls to review the governance of falls improvement. A plan to improve oversight to the broader programme of activities is now being developed. This will be linked to Board level reporting including the Clinical and Care Governance Committee.

Tissue Viability

The cohort of teams declared as part of SPSP implementation remains small and does not reflect the broader activities involved in reducing the incidence of hospital acquired pressure ulcers; and it is increasingly recognised that there is a mixture of activities contributing to improvements. The Tissue Viability Steering Group has endorsed a NHSGGC Improvement Programme which will selectively deploy quality improvement methods to areas requiring better results. The noted reduction in avoidable pressure ulcers within NHSGGC (see chart) has been achieved through the implementation of Pressure Ulcer Daily Risk Assessment (PUDRA) and other supporting activities.

PUDRA is locally developed daily risk assessment tool helps the clinical team identify a person at risk of developing a pressure ulcer. It focuses on a collection of risk factors which are known lead to pressure ulcers developing. The PUDRA process creates a daily review and a record of daily risk of pressure ulcer. Where this confirm the person is at risk is a pre-developed plan of care that support staff tailor the specific interventions to mitigate the risk and limit harm to patients.



2. Healthcare Improvement Scotland Review of Ayrshire Maternity Unit, University Hospital Crosshouse, NHS Ayrshire & Arran (Adverse Events)

The report provided specific recommendations to NHS Ayrshire and Arran. Since publication every NHS Board has been asked to consider how these recommendations would assist in developing their own arrangements. The key recommendations from the report that are pertinent to GGC include:

- Strengthening the adverse event process
- Improving family engagement and communication
- Improved support for staff including dedicated and protected time for staff to be involved in all aspects of adverse reviews
- Promotion of shared learning
- Improved identification of clinical training needs and access to training

The recommendations have been considered within NHS GGC maternity services. This has suggested a small number of improvement opportunities, however many are already part of the current development plan for clinical risk management in obstetric settings. Scottish Government requested an update on the local response from all NHS Boards so a specific action plan has been developed and shared at National Level. This will be reviewed in detail at the next meeting of the Clinical & Care Governance Committee.

The report also has a potential to be used positively for other services. Staff within the Clinical Governance Support Unit are using the recommendations to develop a detailed exploration of the broader policy and practice in relation to Significant Clinical Incidents. This broader review of learning possibilities is to be worked through with clinical governance arrangements over the next few months. It is our intention to develop the content and agree improvement plans with services before bringing a final report back to the Clinical & Care Governance Committee in early 2018. We have also highlighted this internal review needs to be especially robust and well documented, in consideration of the potential for Quality of Care inspections to be put in place by HIS early next year.