NHS Greater Glasgow & Clyde

NHS Board Meeting

Medical Director/Nurse Director **19 December 2017** **Paper No: 17/65**

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

- Hospital Standardised Mortality Ratio
- Mental Health Clinical Safety Programme
- NASA visits NHS GG&C
- Datix Annual Report
- Clinical & Care Governance Committee

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 **Paper No. 17/65**

CLINICAL AND CARE GOVERNANCE REPORT (up to December 2017)

Introduction

NHS GG&C maintain an extensive set of clinical governance arrangements to satisfy the duty of quality set out in the Health Act 1999. There are numerous detailed reports being reviewed in the local clinical governance forums. These are structured around an agenda following the domains of clinical quality and governance set out in NHS Scotland National Quality Strategy, as follows:

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

This report provides the NHS Board with a short, illustrative summary of clinical governance activities, selected from the more extensive activities and reports across the clinical governance arrangements. In particular the content reflects the direct oversight roles of the Board Clinical Governance Forum and of the Clinical and Care Governance Committee.

This report focuses on an overview of

- Hospital Standardised Mortality Ratio (HSMR)
- Mental Health Clinical Safety Programme
- NASA visits NHS GG&C
- Datix Annual Report
- Clinical & Care Governance Committee

The Board of NHSGGC is asked to;

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

HSMR Update to Second Quarter 2017 (Apr-Jun)

The national publication of the Hospital Standardised Mortality Ratio (HSMR) data on 21st November 2017 included data up to the quarter April – June 2017. In this quarter the SMR for Scotland was 0.86. The HSMR for NHSGGC is reported in four hospital groupings, which reflect the pathways of care in each area. All four hospital groups are showing reductions since the baseline period of 2014, however the HSMR at RAH/Vol continues to be reported as significantly above the national average.

The HSMR at Royal Alexandra Hospital/ Vale of Leven Hospital (RAH/VoL) for this period is showing a reduction from the preceding quarter. Please also note that the HSMR at RAH/VoL for the preceding period (Jan-Mar 2017), has been revised down and is no longer reported as significantly above the national average. This is as a result of the data quality improvements and resubmission of data for the Vale of Leven.

Background

An established aim of the Scottish Patient Safety Programme is to reduce hospital mortality. The current aim is a reduction of 10% by December 2018. Information Services Division (ISD) has produced quarterly hospital standardised mortality ratios (HSMR) for all Scottish hospitals participating in the Scottish Patient Safety Programme (SPSP) since December 2009.

The HSMR is based on all acute inpatient and day case patients admitted to all specialties in Scottish hospitals. The calculation takes account of patients who died within 30 days from admission; and includes deaths that occurred in the community as well as those occurring in hospital. To calculate an HSMR, the risk of dying for particular patient subgroups (e.g. age, sex, primary diagnosis, type of admission, number and severity of illness etc.) is calculated based on the standard population (Scotland) at a set period of time – known as the baseline period. This is used to generate a predicted mortality based on information provided from coding forms which is then compared to the actual number of patients dying within 30 days of admission.

In response to a higher than expected HSMR the Board follows nationally advised practice. The advice on interpreting HSMR is that it cannot be considered in isolation from other information. So the first step is to consider other quality of care indicators. Information on clinical performance, complaints, adverse events and patient feedback has been reviewed for both the RAH and VoL hospitals. The second step is to seek external perspectives on the response and interpretation of the information on quality. The third step is to identify and resolve any matters relating to the quality of information used to create the HSMR.

NHS GG&C hosted a review visit from the national leads for HSMR, on 30th November 2017, who independently scrutinised our approach. The formal communication of their findings is yet to be received but on the day the visiting reviewers confirmed that they were assured the Board has addressed this situation in an appropriate and diligent manner. Furthermore, following a visit to a ward at Vale of Leven hospital and presentations of clinical indicators from a medical, surgical and nursing perspective, the visiting team were positive about the quality of care described. The management team's emphasis on a local programme of continuous quality improvement was also commended. The existing actions to further resolve the ongoing data quality were considered prudent. There is a structured plan to apply in a number of departments within the RAH the same targeted improvements to the coding process which have been effective at the VoL. Finally a number of joint actions to improve public communication and data submission methods were agreed with the national leads.

Mental Health Clinical Safety Programme

The Mental Health services in NHS GG&C have evolved a clinical safety programme, building on participation in the Scottish Patient Safety Programme (SPSP). There are a number of different work-streams active with the programme. A short update on each of the four clinical elements is described in the following section. A fuller update is provided on the fifth domain of the programme which looks at ways in which staff are working together, with patients, to ensure safety is a priority.

Background Information

The aim of the safety programme, which is linked to SPSP, is that - Patients are and feel safe, Staff are and feel safe. The objective of the programme is to improve clinical quality across all aspects of mental health services within NHS Greater Glasgow and Clyde by 2020. The programme is managed through the Mental Health Quality Improvement Group.

In addition to the leadership workstream there are four clinical work-streams

- Risk assessment – The need to assess and tailor a plan of care for acutely ill patients is supported by a structured tool and documented procedures. The programme aims to ensure that risk assessment and its documentation are completed with a greater level of reliability.
- Communication at transitions - It is recognised from the national confidential inquiry and local experience that occasionally poor communication when patients move between teams can affect the quality of care. The programme aims to provide a standardised process for discharge ensuring that all patients are aware of the plan, including prescribed medication and follow up appointments.
- Medication - In NHS GG&C we have developed beyond SPSP to ensure that there are structured prompts to assist the use of "as required" medication and to ensure that there is review within each MDT to confirm that they are administered appropriately and for the appropriate reasons.
- Restraint – A number of factors mean that there are a number of violent incidents involving the use of restraint. The programme aim is to reduce restraints by 30%

by December 2017. The pilot involves working with the wards to ensure debrief is used after each incident and individualised care plans are in place for patients at risk.

The clinical teams have developed the reliable use of the designed clinical risk screening tool through the pilot wards. The service is now moving to large scale implementation, seeking to consolidate and roll out good practice to all settings. A new Mental Health Service Clinical Risk Screening and Management Policy has been published, which promotes and standardises the effective practice developed from the pilot teams. This is accompanied with educational material to reinforce understanding of this key clinical practice. The service has also started work to develop the clinical tool and documents into an electronic record. This will facilitate clinical communication and monitoring of the risk assessment process.

The "As Required Medicines" Bundle is aiming to ensure more effective management of medicines prescribed for discretionary use. There has been steady progress towards reliability in the pilot teams. A "bundle" (i.e. a small set of evidence based practices) for Communication at Transition is being tested to support patient care at points where clinical responsibility passes between teams, such as admission and discharge. The pilot teams have shown improvement in the reliability of the process. In both of these work-streams the initial upward trends tailed off prompting a fuller review. In both cases the way in which data was being gathered proved to be inefficient and is being revised. This is a common challenge in the safety programmes where the need to create easily applied but effective data gathering is not fully resolved. Work to develop a restraint bundle, to support avoidance and safety was more recently agreed and its testing in clinical settings is now underway.

Leadership and the Safety Climate

An important adjunct to the safety improvements within clinical teams is the focus on senior support, collective leadership and the maintenance of a positive safety climate for patients and staff. There are three formal methods in use within mental health to support this:

- An annual Patient Safety Climate Survey (PSCS)
- An annual Staff Safety Climate Survey (SCSC)
- A schedule of safety conversations

The annual PSCS is independently conducted in participating Adult Acute wards by Glasgow Mental Health Network representatives. Each ward receives specific feedback which is used to create local improvement plans. The results are also aggregated, confirming overall increase in the percentage of positive responses since the programme began. The annual SCSC is conducted in a similar way (but is independently conducted by the Clinical Governance Support Unit). The model of Safety Conversations was developed from the Acute Services approach to Leadership Walk Rounds. After a number of years of direct engagement with wards the approach is

currently under revision. The opportunity for more effective interactions of leads and clinical staff is being tested with existing clinical networks, e.g. engaging with the Intensive Psychiatric Care Unit network meetings.
All three of these formal methods are improvement focussed and the following illustrate some of the actions which have arisen from the information gathered:

- Staff are using handovers to greater effect and being encouraged to discuss and resolve any safety concerns between shifts using structured Safety Briefings.
- Staff are making greater effort to encourage patient participation in Multi-Disciplinary Team meetings and more regularly ensuring they elicit patient views prior to each meeting.
- Structured communication tools are in place to enable patients to be more fully included in decision making about their medicines and to encourage patients to be pro-active in asking about medication.
- The ward teams are improving our patient's sense of security by ensuring that at least one member of staff is visible at all times.
- Improved exchange of information between teams when patients are being discharged.
- Each Lead nurse is providing more routine support visits to wards and reinforced their availability via phone to highlight and/or discuss any concerns staff may have regarding patient/staff safety.
- Pharmacy staff are now more frequently attending the weekly MDT reviews to discuss any new medications being considered and highlight any risks associated with commencing same.

CLINICAL RISK MANAGEMENT

NASA visit to NHS GG&C

The QI Connects team in Healthcare Improvement Scotland (HIS) organised the recent visit to Scotland by Dr Nigel Packham, NASA flight safety manager. As part of the visit NHS GG&C was approached to host an education session, acknowledging our strong reputation for clinical risk management. The session was an interesting and stimulating discussion, bringing together specialist staff and various leads from across services. A more formal review of learning is underway but some key insights included recognition of the natural ebb and flow of safety consciousness in organisations, novel ways to graphically represent collected learning across many adverse events and the development of predictive approaches to risk control.

We were informed by HIS that Dr Packham "fed back that he thoroughly enjoyed hearing about the work being undertaken within NHS GG&C to understand, reflect and apply learning from patient safety incidents. He also commented on the positive culture and the professionalism of colleagues participating in the discussion"

Datix Annual Report

NHS GG&C use a commercial software system, Datix, to support reporting, management and information storage linked to risk management. The software contains modules for adverse incident reporting, complaints, claims, risk register and Freedom of Information requests. The management of the Datix support team was switched to the Clinical Governance Support Unit in 2015 and since then the team has worked with services to meet the initial set of corporate requirements for the system. This success has created the opportunity for a number of further developments. The Datix annual report reflects this progress and has been considered by a number of corporate groups. It was positively noted with a number of key achievements highlighted. These include

- Revision of the Complaints module in response to legislative changes was achieved by the deadline of 31st March 2017, and, through negotiations with the Datix supplier, achieved at no cost to the Board.
- There are a number of incident reports which take longer than expected to process. As result of joint work with services across the Board we have achieved 35% reduction in overdue incidents to April 2017. This work is continuing to have an impact and we have seen a further reduction of 24% of overdue incidents to October 2017.
- There is a major programme of work to support the clinical teams operate high quality morbidity and mortality meetings. A local design, using a modifiable part of the software suite, has led to the successful development and deployment of electronic forms which aid clinicians in reviewing ad report potential cases. We are currently working with eight clinical specialties and have integrated our work with the national approach to improve morbidity and meetings.

Morbidity and Mortality Meetings

Morbidity and mortality (M&M) meetings are a traditional, peer based approach in which the medical team considers the care of patients where there have been particular challenges. The objectives of a well-run M&M meeting is to learn from complications or unexpected outcomes, to identify examples of good care, to modify behaviour and judgment based on previous experiences. The meetings are non-punitive and focus on the goal of improved patient care. M&M meetings are also important for identifying systems issues (e.g., policy changes, changes in patient procedures, causes of complications and adverse events, etc.) which affect patient care.

- Management of the software has improved by ensuring the version in use is the most up to date, an annual health check by the vendor was conducted with a successful outcome noted and we achieved Datix Reference Customer Status in March 2017.

- Reports using information stored on Datix are routinely reviewed by a range of groups and a new project has created links into the nursing dashboard so staff can easily see real time data on falls and tissue viability data.

Clinical & Care Governance Committee

The Clinical & Care Governance Committee is a standing sub-committee of the Board providing Non Executive oversight to clinical governance arrangements. The December of meeting of the committee explored a range of topic areas including the following key areas:

- The Committee was advised and welcomed a recent review of role and way of working by the internal auditors. Provisional findings suggested a good level of performance with only a small number of minor issues likely to require attention.
- The Committee reviewed arrangements for the governance of prison healthcare and in particular was assured as to improvements and evidence being prepared for re-inspection at Low Moss Prison.
- The Committee reviewed an extensive set of risk management actions to minimise infection risks in developing new facilities for patients.
- The Committee considered a broad ranging report from Maternity services noting the ongoing changes to clinical risk management. In particular the benefits of the new information system currently being implemented are eagerly anticipated in enabling better use of data to further develop clinical quality.
- The Committee reviewed the major clinical risks form the corporate risk register confirming the scope of current risks appeared consistent with expectations and aligned to the agenda items reviewed in its meetings.