



# Clinical Governance Annual Report 2016-2017

NHS GREATER GLASGOW & CLYDE	Custodian: Head of Clinical Governance
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## 1. Introduction

The Health Act 1999 requires that every NHS Board in Scotland must:

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

This statutory Duty of Quality applies to all services NHS Greater Glasgow and Clyde (NHSGG&C) provide in connection with the prevention, diagnosis or treatment of illness. It includes services that are jointly provided with other organisations. Essentially NHSGG&C must satisfy this duty of quality through internal arrangements and also through effective collaboration with partner organisations.

The framework of arrangements we put in place to meet this Duty of Quality, and all its associated activities, is referred to as CLINICAL GOVERNANCE.

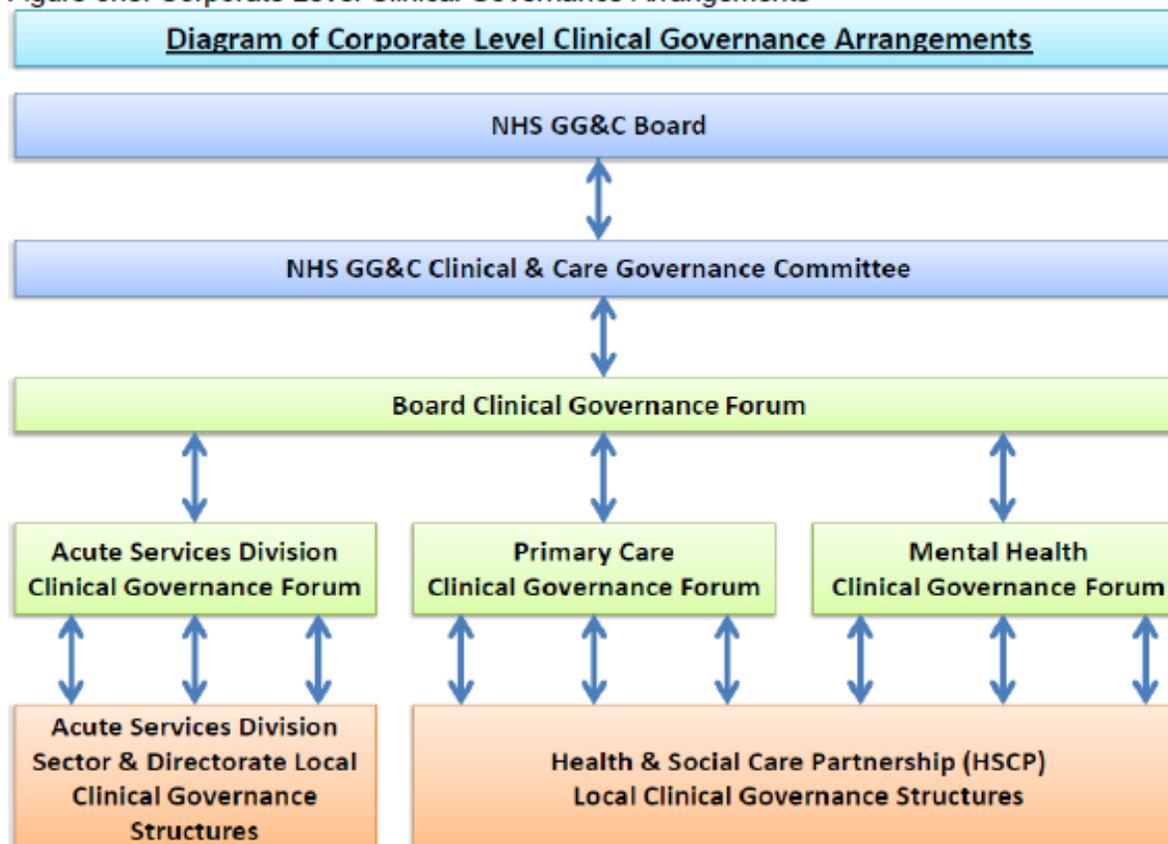
- 1.1 Each year the Board provides an annual report reflecting on its clinical governance arrangements and the progress it has made in improving the quality of clinical care. The report is structured around the three main domains set out in the National Quality Strategy: Safe, Effective, Person-Centred Care. This report will describe the main governance framework and demonstrate our work to improve the quality of care in our Board through a small selection of the activities and interventions. It is important to note that there is substantially more activity at clinician, team, and service level arising from our shared commitment to provide a quality of care we can be proud of. This report can only reflect a small selection so is illustrative rather than comprehensive.
- 1.2 As we entered this year we were continuing to ensure the clinical governance arrangements had been updated following a period of substantial change in 2015/2016, which included the establishment of Health and Social Care Partnerships (HSCPs) and of course the opening of new Queen Elizabeth University Hospital and the new Royal Hospital for Children.

NHSGG&C, one of 14 territorial NHS Boards in Scotland, was formed in April 2006. It covers an area of 452 square miles in west central Scotland, providing services to a core population of 1.1 million. The organisation covers a diverse geographical area, including Glasgow, the largest city in Scotland, large and small towns, villages, and coastal and rural areas. We employ around 38,000 staff who deliver services across its core area, as well as regionally and nationally, providing specialist regional services to more than half of Scotland’s population. We are responsible for the provision and management of the whole range of health services in this area including hospitals and General Practice. NHSGG&C also works alongside partnership organisations including Local Authorities and the voluntary sector.

## 2. Clinical Governance Arrangements

- 2.1 During this reporting period (April 2016 to March 2017) the governance of clinical quality has been overseen by the NHSGG&C Board and through its standing sub-committees. During the year, as a result of the reorganisation within the NHSGG&C, the Clinical and Care Governance Committee was created and met for the first time in January 2017. This sub-committee is led by Non Executive Board members who take an overview of clinical governance and, on behalf of the Board, seek assurance that clinical governance arrangements are working effectively to safeguard patients and improve the quality of clinical care. The corporate arrangements for clinical governance are currently as described in Figure one.

Figure one: Corporate Level Clinical Governance Arrangements



2.2 The Medical Director and Nurse Director, as Executive Leads for Clinical Governance lead the Board Clinical Governance Forum, which strategically coordinates the clinical governance arrangements. The Forum receives reports from the key service areas at every meeting as well as a range of thematic reports on issues relating to person-centred care, clinical safety and clinical effectiveness. In addition, individually commissioned reports and local service updates are also considered as part of the broader assessment of the effectiveness of the arrangements.

### The scope of the Board Clinical Governance Forum

The agenda of the Board Clinical Governance Forum contains a set of regularly reviewed topics and responds to specific items of interest. In the last year the items which were routinely discussed as part of the meeting were:

- Quarterly Clinical Risk Management Reports – Acute, Mental Health & Partnerships
- Confirming Improvement Following Serious Clinical Incidents (SCI's)
- Overall Board Clinical Governance Report – Including CG Stakeholder Event Feedback
- Child Protection Update
- Adult Support & Protection Update
- Clinical Effectiveness Report
- Hospital Standardised Mortality Ratio (HSMR) Update
- Mental Health Update – Including Physical Health Care for Patients with Mental Health Problems
- Acute Services Update – Including Unscheduled Care Update
- HSCPs Primary Care Update – Including Quality in GP Clusters Framework
- Pharmacy Service Update
- Controlled Drugs Accountable Officer Report (Apr – Sept 2016)
- Research & Development Update
- Feedback from Clinical & Care Governance Committee

- Infection Control Summary – Healthcare Associated Infection Reporting Template
- Putting Patients First – Implementing the Patient Rights Act in NHSGG&C Acute Services

Some examples of the topics which had specific consideration as part of the meeting included:

- Medical Professional Accountability 2016
- Review of Acute Services Division Clinical Governance Arrangements & Map of Structure
- Internal Audit of Clinical Governance Arrangements & Action Plan
- HSCP Governance Arrangements
- Scottish Breast Screening Programme & National Bowel Screening Programme – Progress Update
- Electronic Referral System
- Developing Clinical Governance Strategy – Workshop Update
- Scottish Intensive Care Society Audit Group
- Preventing Alcohol Related Mortality
- Area Drug & Therapeutics Committee Response to Healthcare Improvement Scotland Request on Scottish Patient Safety Programme Medicines
- Clinical Risk Management in Maternity Services

- 2.3** Each of the clinical service structures (i.e. HSCPs, Acute Sectors and Directorates) have their own Clinical Governance Forums, which are in turn linked with other groups at specialty and sub-specialty level. The broad network provides significant opportunity for local clinical teams and managers to contribute to clinical governance.

In East Renfrewshire HSCP the Clinical & Care Governance Group operates as follows:

The role of the Clinical and Care Governance Group is to consider matters relating to Strategic Plan development, governance, risk management, service user feedback and complaints, standards, education, professional registration and validation, learning, continuous improvement and inspection activity.

- Specifically the group is responsible for the following:
- Providing assurance to the Integration Joint Board (IJB), the Council and NHS Board, via the Chief Officer, that the Professional standards of staff working in Integrated Services are maintained and that appropriate professional leadership is in place;
- Reviewing significant and adverse events and ensure learning is applied;
- Supporting staff in continuously improving the quality and safety of care;
- Ensuring that service user/patient views on their health and care experiences are actively sought and listened to by services;
- Creating a culture of quality improvement and ensuring that this is embedded in the organisation.

The group is chaired by the chair of the Integration Joint Board, along with Integration Joint Board members, membership includes Chief Officer HSCP, Clinical Director, Chief Social Work Officer, Professional Nurse Advisor, AHP Professional Lead, GP representative, Optometry Lead, Pharmacy Lead, NHSGG&C Clinical Effectiveness representative, Third and Independent Sector representatives, and patient and carer representatives.

- 2.4** The Non Executive members of the Board provide oversight of the clinical governance arrangements, which is an important basis of regular scrutiny. Additionally, the Board uses Internal Audit as a means of independently checking the effectiveness of arrangements. A report in May 2016 identified good progress in revising the arrangements following on from the organisational changes but also suggested

a small number of opportunities for further progress. The agreed actions were confirmed as completed by the Board Clinical Governance Forum and the Clinical and Care Governance Committee.

In response to the Internal Audit Report a review of clinical governance arrangements in Acute Sectors and Directorates was completed and approved at the June meeting of the Board Clinical Governance Forum. The consistent management of Clinical Governance Forums was enabled by additional guidance and templates for reporting. Additional communication to reinforce links with HSCPs has also been provided which recognises the HSCPs are adapting to support integrated health and social care governance groups.

**2.5** In last year's report a broad set of development aims were outlined. These informed the broad scope of work that is described in the report. For instance there are examples of:

- Key improvement programmes for clinical safety and patient experience in section three and four (aim to work at larger scale).
- Lessons generated and applied as a result of adverse events in section four (aim to learn when things go wrong).
- Training of staff and development of their ability to apply quality improvement techniques in section five (aim to develop QI skilled clinical teams).
- Effective use of data to visualise and confirm that improvement projects are effective in improving quality in section five (aim to use information effectively).
- The production of clinical guidelines to ensure high quality clinical practice in section five (aim to enable evidence based practice).
- Independent confirmation that the clinical governance arrangements are well embedded in section two (aim to ensure robust support and monitoring).
- The use of external quality publications in section five (aim to apply lessons from external sources).
- The monitoring of key programmes to enhance their effectiveness in section two and five (aim to ensure effective progress).

### **3. Person-Centred Health and Care Programme**

“The way people experience health and care is an important component in delivering quality support and care services. Evidence suggests that a focus on person-centred care can result in improvements in health behaviours, and health and wellbeing outcomes.

Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively make informed decisions and be involved in their own health and care. It ensures that care is personalised, co-ordinated and enabling so that people can make choices, manage their own health and live independent lives, where possible.”

From Healthcare Improvement Scotland at <http://ihub.scot/a-z-programmes/person-centred-health-and-care/>

The Nurse Director publishes the Annual Report on Feedback, Comments, Complaints and Concerns which provides a greater demonstration of the way in which the Board is responding to feedback to ensure care is safe, effective and person-centred.

This is available on the NHSGG&C website at <http://www.nhsggc.org.uk/about-us/publications-library/?id=236751>

**3.1** NHSGG&C is aligned to the national person-centred health and care programme (PCHC) through the work of the PCHC Programme team. The team gather “real-time” feedback from people using services to resolve concerns and create cycles of improvement activity. The feedback concentrates on ‘what matters while they are receiving care’ and their experience of the person-centred principles of care giving.

**3.2** The team support three project areas:

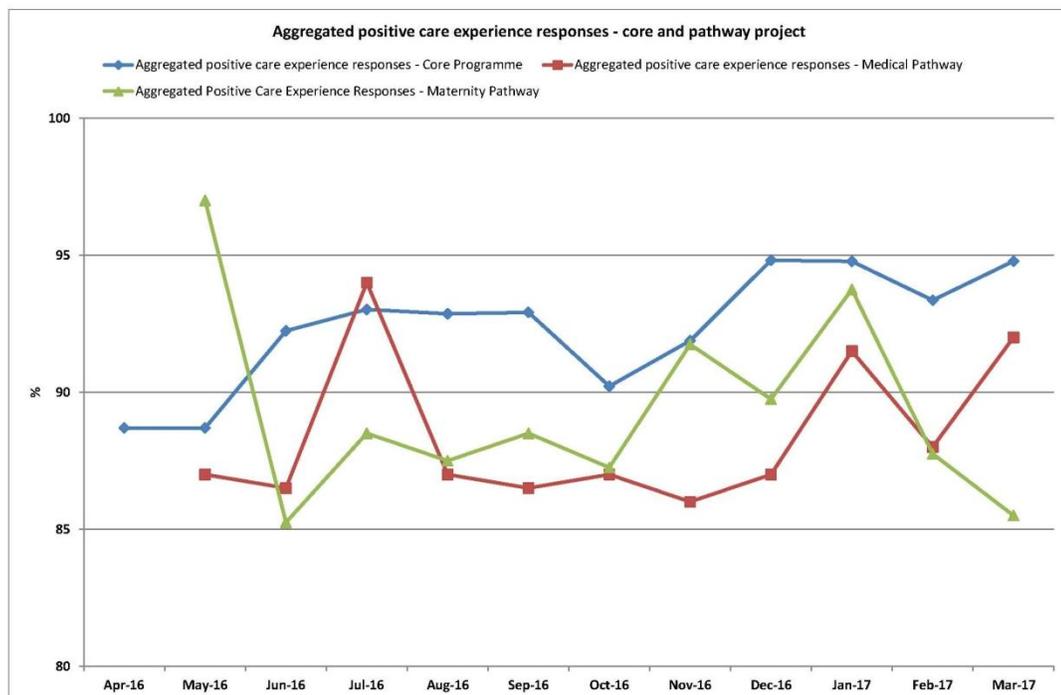
- A core of twenty-one diverse care teams spread across four Sectors and Directorates within the Acute Services Division (ASD) aims to improve people’s care experience at an individual care team level
- Teams in the medical pathway at Glasgow Royal Infirmary
- Teams in the maternity pathway at the Royal Alexandra Hospital and Queen Elizabeth University Hospital

**3.3** From April 2016 – March 2017, one thousand two hundred and twenty-six (1226) people have accepted the invitation to provide care experience feedback.

**3.4 Results**

**3.4.1** The care experience is reported as positive by the majority of people providing feedback. In the core, programme the range of positive care experience responses range from 89 – 95% with a median of 93%. The range of positive care experience responses for the medical pathway range from 81 – 91% with a median of 85% and in the maternity pathway, the range is 82 – 92% with a median of 85%. This is represented in chart one.

**3.4.1.1 Chart 1: Aggregated Positive Care Experience Responses – Core and Pathway Project**



**3.5 Themes from Feedback**

**3.5.1** The four predominant themes emergent from the feedback across both portfolios of work are relatively consistent over time and can be categorised into four broad themes:

- Consistency and coordination of care.
- Communication and involvement in care.
- Respect, dignity and privacy whilst receiving care.
- Safety – in particular related to delay experienced in calls for assistance.

### 3.6 Improvement Examples

3.6.1 There are a number of improvement projects undertaken across both portfolios of work. The following are a few examples:

#### 3.6.1.1 Ward 4C, Regional Renal Transplant Ward, Queen Elizabeth University Hospital

Care experience feedback in ward 4C identified that people’s individual choices, preference and care needs were not always recognised. Consequently, what really matters to people was not fully understood or acknowledged when discussing and planning care. The care team have implemented a conversational approach to find out “what matters to you (WMTY)?” on a daily basis to ask, listen and do what matters. An evaluation of the plan of care takes place daily to assess if ‘what matters’ was achieved and if not to find out and understand why not. Since implementing this improvement approach, the care experience has improved against the following measures over the period April 2016 -17:

1. **‘Ask what matters...’** People have reported an increase from **70% to 100%** when asked, “*Were you asked ‘WMTY today’ during your nursing observations?*”
2. **‘Do what matters...’** People have reported an increase from **90% to 100%** when people are asked, “*Do you feel the staff always consider your needs and preferences and the things that matter to you when caring for you?*”
3. **Outcome** – People have reported a positive experience of communication and involvement in their care of **95% and above** since June 2016.

Asking, listening and acting on “what matters to you?” has shown relatively rapid improvements in overall care experience. The improvement approach has increased staff confidence and understanding of the importance of asking “what matters to you?” and the necessity of the enquiry as people’s condition and circumstances change. The improvement approach is now being shared and spread to other care teams.

Feedback from people being care for in ward 4C and their relatives is testament to the positive experience achieved from this improvement.

*“I think this board is fantastic! It really allows you to express what you want people to know about you. It makes me feel the staff get to know the real me.”*  
(Patient)

*“This board is brilliant! It helps with letting others working with my brother; know more about him and his life. I would like to see space for photo’s on the board to display his happiest times, to let staff see him in a different environment.”* (Relative)

*“Being asked ‘what matters to me’ is the most important question I’ve ever been asked. After my transplant it has helped me focus my recovery.”* (Patient)

*“My kids took ownership of the board. It is a great thing to be asked; it has meant the world to me to be here and staff asking ‘who’s important?’ and ‘what’s important?’”*  
(Patient)

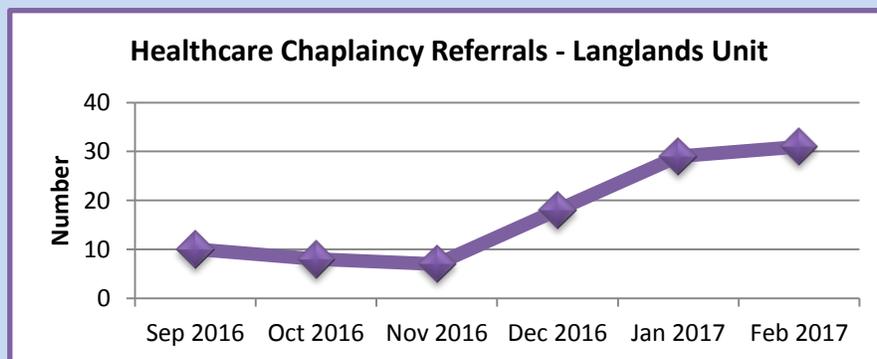
### 3.6.1.2 Langlands Unit, Older People Assessment Wards and Stroke Rehabilitation, Queen Elizabeth University Hospital

Care experience feedback in the Langlands Unit from people and their relatives demonstrated that spiritual care needs were not consistently identified and addressed.

***“I have a strong faith but was too scared to ask for a Priest to come and see me. The staff are always so busy running in and out.” (Patient)***

During conversations with staff, it became apparent that the referral process was not clear to all; there was a knowledge gap about the services and support healthcare chaplaincy could offer to patients, relatives and staff. The care team instigated a series of improvement interventions with an aim of ensuring all patients were offered the opportunity to be referred for spiritual care support on admission and throughout their care whilst in the Langlands Unit. The improvement approach included testing different ways of asking questions about spiritual care needs to enquire and find out if individuals would like to speak with someone independent of the care team. Staff also observed people for signs of change in behaviour and/or mood as an opportunity to enquire how they were feeling and to offer spiritual care support from the healthcare chaplain.

Since implementation of the change concepts, there has been an increase in the number of referral made to the Healthcare Chaplaincy Service over the course of six months from 7 – 10 referrals to 30 referrals in February 2017.



Care experience feedback over this six month period has also demonstrated a positive response from people who have requested and been referred for spiritual care support.

***“I have a strong faith and the hospital Chaplain has been in to see me five times already.” (Patient)***

***“All the nurses are very kind, even when they’re short staffed. The Chaplain comes to see me and that’s important to me.” (Patient)***

***“My own minister has been in to see me twice and the hospital Chaplain has also seen me twice. The male HCSW came with me yesterday to the eye clinic and it was lovely to have a familiar face there with me.” (Patient)***

The care team now realise the importance of spiritual care assessment being integral to the assessment process and that this needs to be addressed at times of transition of care and when peoples condition and circumstance changes.

## 4. Patient Safety & Clinical Risk Management

### 4.1 Introduction

4.1.1 It is the experience of all healthcare systems across the world that patients will occasionally suffer harm whilst being cared for. NHS GG&C seeks to minimise the frequency and degree of such instances of patient harm through an approach collectively described as clinical risk management.

**“Clinical risk management** specifically is concerned with improving the quality and safety of healthcare services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risks”. (World Health Organisation Patient Safety Guide)

The following simple four-step process is commonly used to manage clinical risks:

- Recognise and report adverse events leading to patient harm;
- Review events (using Root Cause Analysis) to identify how harm could be prevented;
- Implement changes that can improve that safety of clinical care;
- Monitor the progress in reducing clinical risk.

In NHS GG&C clinical incident reports are made through an electronic system (Datix). There is a tiered approach to incident review with the most robust investigation undertaken for events falling within the definition of Significant Clinical Incidents. Each (SCI) investigation is tracked from the initial report through a managed process to confirmation that any resulting actions are complete.

4.1.2 In reviewing the following section on safety it is important to understand that for the majority of patients their care is delivered without mishap or an adverse outcome. It is also helpful to understand the scale of activity associated with NHS GG&C. Each year, for instance, our acute hospitals will have treated and discharged in excess of 350,000 patients in wards or in day care. In community services GP and practice staff will have seen over 1 million patients, community nurses provided around 1.5 million visits to patients in their own homes and over 20 million medicines were dispensed by Community Pharmacists.

### 4.2 Significant Clinical Incidents (SCIs)

4.2.1 The Board maintains a Significant Clinical Incident (SCI) Policy, which sets out robust requirements to identify clinical events offering the greatest opportunity to improve safety. The following charts provide an outline of our experience of Significant Clinical Incidents reported since April 2008. An important point to recognise is that the number of incidents reported is not necessarily an indicator of poor clinical performance. The SCI policy is used to investigate incidents including near miss situations where no immediate harm was suffered and a proportion of reported events are unavoidable, arising from the complex presentation of seriously ill patients.

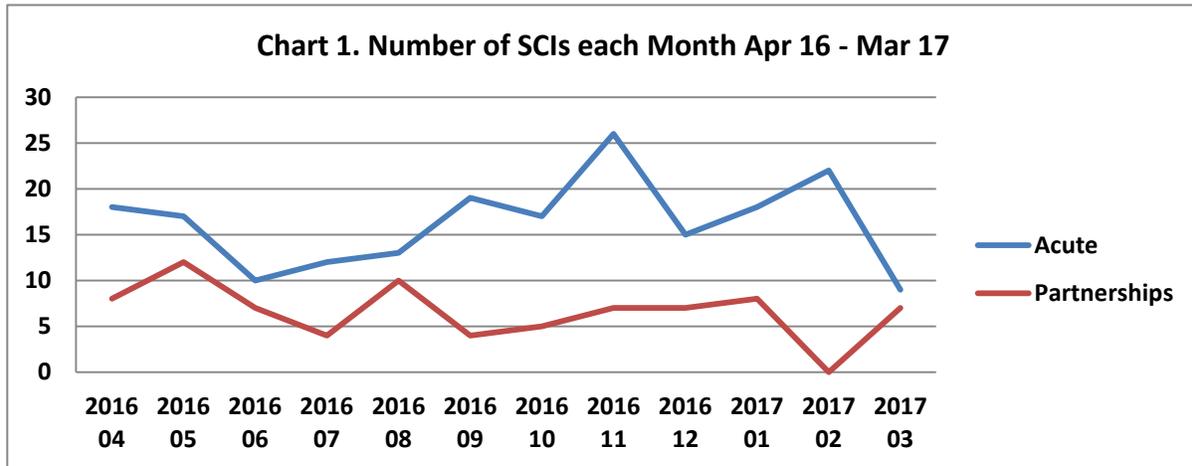
	Acute	Partnership
08/09	46	82
09/10	67	61
10/11	77	71
11/12	71	52
12/13	99	52
13/14	138	66
14/15	162	88
15/16	186	78
16/17	196	79
<b>Totals:</b>	<b>1042</b>	<b>629</b>

The table opposite identifies the number of SCI's by financial year since recording this information on Datix in 2008. It is notable that there is a steady increase in reporting within Acute with a more stable reporting level in Partnerships.

The Acute statistics are due to an increasing awareness of the SCI process combined with an increased use of this type of investigation. So for example when SCIs were first introduced it was mainly for patients with an outcome of death or serious injury whereas now we investigate near miss incidents as our main focus is for learning.

4.2.2 The Partnership statistics reflect that a SCI review for a patient suicide has been standard practice since 2008 and the majority of these events are suicide. Although there has been a slight decrease in the number of suicides there is a slight increase in the other Partnership events so the data does not reflect significant changes.

4.2.3 From April 2016 to March 2017, a total of **275** clinical incidents were escalated to SCI status, demonstrated in chart 1 below (Acute – 196, Partnership 79). In 149 of these events we have concluded the investigation. This has identified that 41% of incidents were not avoidable leaving 59% that were concluded to be the organisations responsibility.



4.2.4 There has been increased effort over the last year to share the learning following Significant Clinical Incident investigations utilising a Learning Summary template (example opposite). These one page learning summaries are part of the SCI toolkit. The purpose is to provide a one page summary of learning from a serious event that has the potential to occur again.

They can be used locally, Board wide and be reported nationally on the HIS Adverse Events Community of Practice site.

In GG&C we have started using these for medication errors but plan to expand their use for other events.

Not all SCIs will produce a learning summary as they are not always appropriate. They are best used to raise awareness and to share how a risk has been reduced – so not only sharing the problem but also the solution.

Learning summaries are stored on the clinical risk staff net page.

The learning summary template has also been adapted to use for other communication needs.

**Clyde Sector Medication Incident Learning Report**  
 Sharing criteria: Clyde Sector / NHSGCC / National  
 Category: Significant Clinical Incident  
 If other, please specify: Medication Incident

Sharing Learning Points  
**LOCALLY AND NATIONALLY**

**What happened?**

Patient admitted with sepsis.

She was prescribed a second dose of GENTAMICIN without checking serum Gentamicin level and that days U&E's.

Two nurses gave her the second dose – both thought it was not their role to ensure Gent level and U&E's had been checked

The patient suffered an acute kidney injury secondary to GENT toxicity and needed 11 days of renal dialysis.

**What went well?**

- Staff reacted quickly once recognised instigating essential supportive management
- Although this Incident was not reported as an SCI at the time the Registrar involved had taken it to his supervisor and had debriefed the incident. He reported during interview he gained a lot of personal learning from his prescription error

**What, if anything, could we improve?**

- Processes around prescribing and administration of Gentamicin
- Knowledge and awareness of GENT chart
- Use of 'Chance to Check' prior to administration of medicines

**What have we learnt?**

- If you are not familiar with a medicine, always check indication and dose
- We need to ensure this knowledge gap is addressed both locally and across the acute
- Pharmacists DO NOT review every patient every day – DO NOT rely on someone else to check prescriptions or medicines
- Consider contacting the medicines Information Centre for advice (Tel 0141 211 4407)
- Incidents can repeat themselves, always report and share learning

Produced by the Clyde Sector Medicines Governance Committee.  
 If you have any comments about this or any similar adverse event please send them to acute.clinicalrisk@ggc.scot.nhs.uk.

**4.2.5** Another method to raise awareness and reduce risk is the production and distribution of Risk Awareness Notices, which are short summaries of newly recognised risks. These are produced as soon as possible following awareness of the issue to ensure the service are alert to the risk and take action where necessary. Within this time period 9 notices have been produced. Some examples are listed below.

**Examples of Risk Awareness Notices:**

- Risk of fall from Emergency Department trolley
- Risk of user error with new medical gas cylinders
- Risk of wrong dose of Morphine ampoules for injection
- Risk when removing Central Venous Catheter

<http://www.staffnet.GG&C.scot.nhs.uk/Corporate%20Services/Clinical%20Governance/Clinical%20Risk/Pages/RiskAwarenessNoticesPage.aspx>

**4.2.6** There have been a number of improvements that have taken place following review of significant clinical incidents. These can either be following individual events or following analysis on a cluster of events. Some examples are included below.

**Example of improvements following SCI:**

Acute

- Dermatology has introduced a new surgical safety checklist for use in outpatient clinics where minor procedures such as lesion removal are taking place to reduce the risk of errors in the procedure.
- A checklist/aide memoir for insertion and removal of Central Venous Catheter lines has been developed and implemented for critical care departments.
- A new Calcium Channel Blocker Overdose Protocol has been produced and Emergency Department staff have already found the use of this protocol and in particular the use of Intravenous Insulin and Dextrose therapy particularly effective in high risk overdoses

Partnerships

- Mental Health has developed a suicide prevention policy.
- Mental Health has developed a risk screening and management policy incorporating a new framework to assess patients for the risk self harm.
- Sepsis guidance and information about the Sepsis screening app has been communicated to all GP's.

**Discrepancy Meetings in Diagnostics Directorate**

Since June 2016 the Directorate has been reviewing and updating our processes and governance for Learning from Discrepancies for Imaging in NHSGG&C. As indicated in the comprehensive standards document, (Standards for Learning from Discrepancies meetings - BFCR (14)11), errors are an inevitable part of normal practice but should be dealt with to form the basis of learning. This document includes a comprehensive list of standards on which this learning should be based.

Each Sector has an identified discrepancy clinical lead who chairs the local discrepancy meetings in all the Sectors and they all attend the Discrepancy Leads meeting, which is chaired by a Deputy Clinical Director. Beyond this we are collating the local discrepancy meeting outputs for the whole of Imaging in GG&C. This is allowing us to look for patterns and address system errors. We are actively looking at methods to disseminate the learning to the whole Board as opposed to the local Sectors and Directorates as has happened historically. We are constantly reviewing how we handle these cases to improve performance.

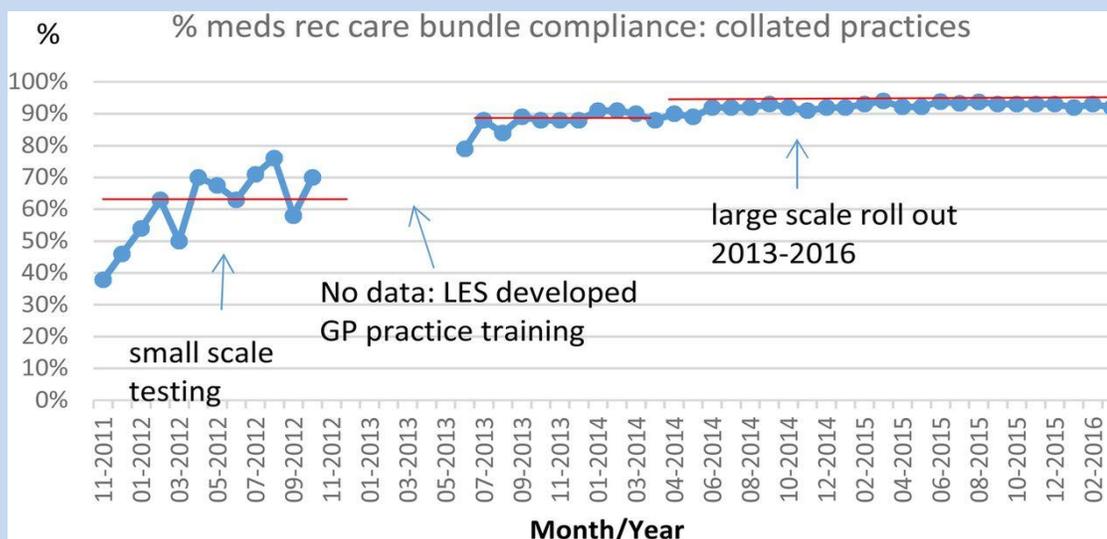
### 4.3 Promoting Medicines Safety

4.3.1 The beneficial role of medicines is well recognised but, given the volume of medicines prescribed and those which carry side effects, promoting medicines safety is an important aspect of clinical governance.

4.3.2 Medicines Reconciliation enables prescribers to understand and review the patient's use of medications prior to admission and discharge from acute hospitals. As a result of ongoing efforts around 80-90% of patients can be confirmed as having an accurate prescription Kardex within 24hrs of admission. In primary care the implementation of the medicines reconciliation bundle in GP practices has improved patient safety post discharge (this work was published in an internationally renowned journal).

#### Implementation of a Medicines Reconciliation (MR) Care Bundle in NHSGG&C GP Practices

The aim of the project was to test the Scottish Patient Safety in Primary Care (SPSP-PC) MR care bundle (i.e. a customised set of evidence based practices) and consider scale up and spread across all NHSGG&C GP practices. Pilot work and testing began with 5 GP practices in 2011 and was spread to over 200 practices by 2015/16. Practices used PDSA cycles to test and implement improvements. The process data was collated at NHSGG&C level with an aim of 95% reliability by March 2016. The chart shows progress from an initial position of 40% reliability in 5 practices during 2011, with final data in March 2016 demonstrating 92% compliance in 192 participating practices. A sustained "reliability" of 92-93% across >200 practices has been observed since January 2015. In conclusion, the bundle was implemented by 97% of NHSGG&C GP practices and resulted in process improvements.



*BMJ Quality Improvement Report 2016;5: doi:10.1136/bmjquality.u212988.w6116*

## 5. Clinical Effectiveness

### 5.1 Clinical Guideline Electronic Resource Directory

5.1.1 The Institute of Medicine defines clinical guidelines, as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." NHSGG&C recognised the need to improve the process for clinical guideline development, approval and review, and commissioned the development of a Clinical Guideline Framework and Directory to enable their storage and retrieval in 2012. The framework and directory underwent a period of

consultation and review during 2015. Feedback was collated, themed and taken into consideration. The updated framework and directory were launched on Thursday 11<sup>th</sup> February 2016.

**5.1.2** Recent feedback from services on the NHSGG&C Guideline Framework has suggested a further consultation and review would be helpful, with a particular focus on approval groups' roles and responsibilities. This consultation will take place June – August 2017.

There were a number of changes to the framework; the most notable change is the steps taken to ensure a guideline is approved as the most appropriate Clinical Governance Committee/Forum. It is anticipated that this change will result in clinical guidelines being tabled at appropriate approving groups with completed checklists, and to improve the effectiveness of the current system.

Other changes include the introduction of a robust archiving process to ensure that each version of clinical guideline which has been uploaded onto the directory is retained and can be easily retrieved, if required.

**17 New Clinical Guidelines have been developed and approved in line with the Clinical Guidelines Framework in 2016 – 2017 and are available on the Guideline Directory** for clinicians to use to support clinical decision making.

**5.1.3** There are currently 442 clinical guidelines posted on the Clinical Guideline Directory.

- 123 are new clinical guidelines (28%)
- 81 are clinical guidelines migrated from the clinical information site (18%)
- 238 are migrated from other StaffNet Pages (54%)

**5.1.4** Of the 442 clinical guidelines posted onto the Clinical Guideline Directory:

- 406 clinical guidelines are current and valid (92%)
- 34 clinical guidelines have breached their review date (8%)

During 2016-2017 the Clinical Effectiveness Team has continued to have a focus to ensure that clinical guidelines remain current and valid. There have been a number of change ideas tested in this time period that have led to a reduction overall in the number of clinical guidelines which have breached their review date. One example is that an email reminder is now sent to lead authors 90 days prior to the guideline review date, providing guideline authors with a word version of the guideline, the guideline checklist and details on what steps need to be taken. This has been viewed as a supportive change in the process by the guideline authors.

## **5.2 Clinical Quality Publications**

**5.2.1** The Board maintains a process to consider the implication of a range of clinical quality publications.

**5.2.2** This role involves:

- Identification of relevant publications
- Preparation of an initial impact assessment of the publication
- Tracking the publication to ensure it has been tabled at an appropriate group, and that an action plan has been prepared where required.
- Presentation of a report to provide oversight and assurance, which is presented to appropriate groups for approval and response

### **Clinical Quality Publications (CQP) Often Relate to National Audit Reports**

The reviewing of clinical quality publications supports clinicians and managers to review the results and to consider any actions to be taken. A summary of the impact assessment is produced jointly by the Clinical Effectiveness Team, and the Clinicians and Managers. This is reported to key Clinical Governance Groups/Forums across the Sectors/Directorates and Partnerships, and then to the Acute Services Division Clinical Governance and Board Clinical Governance Forum, thereby supporting corporate assurance processes.

**37 Clinical Quality Publications have been published in 2016-2017, 33 have been impact assessed and reported at key Clinical Governance Groups, and the remaining 4 are in progress. This process has resulted in a range of improvement actions being identified.**

Overall, 109 Clinical Quality Publications have been identified for review from January 2014 to March 2017. 105 have been reviewed, any actions to be taken considered and a summary report has been tabled at key Clinical Governance Forums.

### **Example of CQP: Health Services for People with Haemoglobin Disorders, Published in May 2016**

A peer review visit was organised by West Midland Quality Review Service on behalf of the UK forum on Haemoglobin Disorders, which took place in 2016 to Glasgow Royal Infirmary and the Royal Hospital for Children.

In line with the agreed process for tracking clinical quality publications, a summary report was produced and identified some areas requiring consideration and action. The publication was reviewed by both the Adult and Paediatric Haemoglobinopathy Services. 10 actions were identified across both services and agreed by both the Women and Children's Clinical Governance Forum and Regional Services Clinical Governance Group. The review of the publication provided the service with the information required to put forward a business case for a 0.5 WTE Clinical Nurse Specialist at Glasgow Royal Infirmary and the Royal Hospital for Children.

**5.2.3** For all cancer quality publications, both the regional annual governance process, and the national governance process, responsibility for action and response will sit with the Cancer Performance Lead, as set out in the local cancer governance arrangements.

### **5.3 Clinical Governance Related Guidance**

**5.3.1** The Clinical Effectiveness Team maintain a system across NHS GG&C for supporting the impact assessment and reporting for the following publications:

- Scottish Intercollegiate Guidelines (SIGN)
- National Institute for Clinical Excellence Interventional Procedures (NICE IPG)
- Healthcare Improvement Scotland Standards (HIS)
- Healthcare Improvement Scotland HIS Clinical Quality Indicators (HIS)

**5.3.2** This includes the dissemination of a monthly newsletter highlighting all new clinical governance related guidance which the NHS GG&C Policy for Addressing Clinical Governance Related Guidance covers. This is e-mailed out across NHS GG&C to a core distribution list and made available via the Clinical Governance Support Unit Intranet site. Feedback from Clinical Leaders advises that this is a very useful summary and helps them to keep abreast of new publications.

- 5.3.3** Emailing a notification of the publication of new guidance to a core distribution list using standard communication processes. This email outlines the organisational response expected as outlined in the NHS GG&C Policy for Addressing Clinical Governance Related Guidance.
- 5.3.4** Ensuring that new guidance is impact assessment within 3 months of publication through an agreed process. The outputs of this are reported to the Acute Services Division Clinical Governance and Board Clinical Governance Forum, and to the key Clinical Governance Groups/Forums across the Sectors/Directorates and Partnerships.
- 5.3.5** 31 publications have gone through the process of assessment and reporting in 2016-2017.

**Example of HIS National Standard:**

**Healthcare Improvement Scotland Standards for the Management of Hospital Post-Mortem Examinations, published in June 2016**

These are a minimum set of performance standards which should be used to reinforce national consistency and drive improvement within hospital post-mortem examinations across Scotland.

The standards were impact assessed by Pathologists for both acute and paediatric services, Mortuary Operations and Service Managers. The review found that NHS GG&C were fully compliant with 27 of the 31 standards. An action plan has since been developed by the Diagnostic Clinical Governance and Safety Committee.

**5.4 Developing Quality Improvement Capacity and Capability**

**5.4.1** Within the theme labelled “system enablers for safety” Healthcare Improvement Scotland (HIS) identify that capability of the workforce to use quality improvement methods and approaches effectively is associated as a factor that may drive improvement. “Building Capability to Improve Safety” (The Health Foundation 2014), highlighted that the best approach would be a menu of opportunities for developing capability that can meet the need for the diverse range of skills and expertise required for support.

**5.4.2** One of the Clinical Effectiveness Team’s declared objectives is to support the development of quality improvement (QI) capability building within NHS GG&C through the delivery of quality improvement educational events, as well as providing ongoing coaching support to delegates as they undertake their own projects within their own working environments. The content of the training allows delegates to understand and apply tools and techniques to support them to deliver sustained improvements in their area of focus.

**5.4.2.1** Since 2014, 21 one day workshops have been held, with a total of 552 individuals attending.

**5.4.2.2** A range of opportunities have been made available in 2016-2017 to support building QI Capability:

- a) One day QI workshops: hands-on workshops to develop the skills, knowledge and confidence to lead, plan and deliver local improvement projects. This has been delivered to 271 delegates during 2016-2017.
- b) Development and implementation of a programme on Leading for QI for Clinical Leaders: 80 Clinical Leaders attended 4 half day workshops on leading for QI in 2016.
- c) 8 Bespoke QI workshops developed and delivered as commissioned by services:
  - PPSU 20<sup>th</sup> April 2016
  - Mental Health Service 28<sup>th</sup> April 2016

- Knowledge Services 19<sup>th</sup> May 2016
- Partnerships 31st May 2016
- Paediatric Nursing staff 5<sup>th</sup> September 2016
- Regional Services 13<sup>th</sup> December 2016
- Allied Health Professionals 24<sup>th</sup> January 2017
- Maternity Services 29<sup>th</sup> March 2017

- d) Development and implementation of QI awareness raising as part of Nursing Making a Difference Development Programme: 308 Nurses (Band 6 and above) attended 4 half day QI awareness raising sessions as part of the Nursing Making a Difference Development Programme in 2016. A schedule of ten half day QI sessions will take place in 2017 for Band 5 Nurses.
- e) In January 2016, an improvement coaching programme was introduced, which offered QI workshop delegates the opportunity to work with an improvement coach for a period of 6 months, to support and guide them through the various stages of their projects. To date 24% of QI workshop delegates have taken up this opportunity. To improve this, an application process has been put in place and requires sign off from delegate's line manager before a place is given on a workshop. The expectation is that all delegates will now complete a QI project post workshop.

## 5.5 Quality Improvement Projects

5.5.1 There is a broad range of clinical effectiveness and quality improvement activities, which are aligned to national, strategic and local priorities. Some examples are as follows:

### **West of Scotland Cancer Centre, Regional Directorate**

The aim of the project is to increase recognition and response time to all patients with a NEWS of 5 or over in Ward B2 Beatson West of Scotland Cancer Centre, drawing on the Scottish Patient Safety Programme workstream on Preventing Deterioration using the Structured Response Bundle.

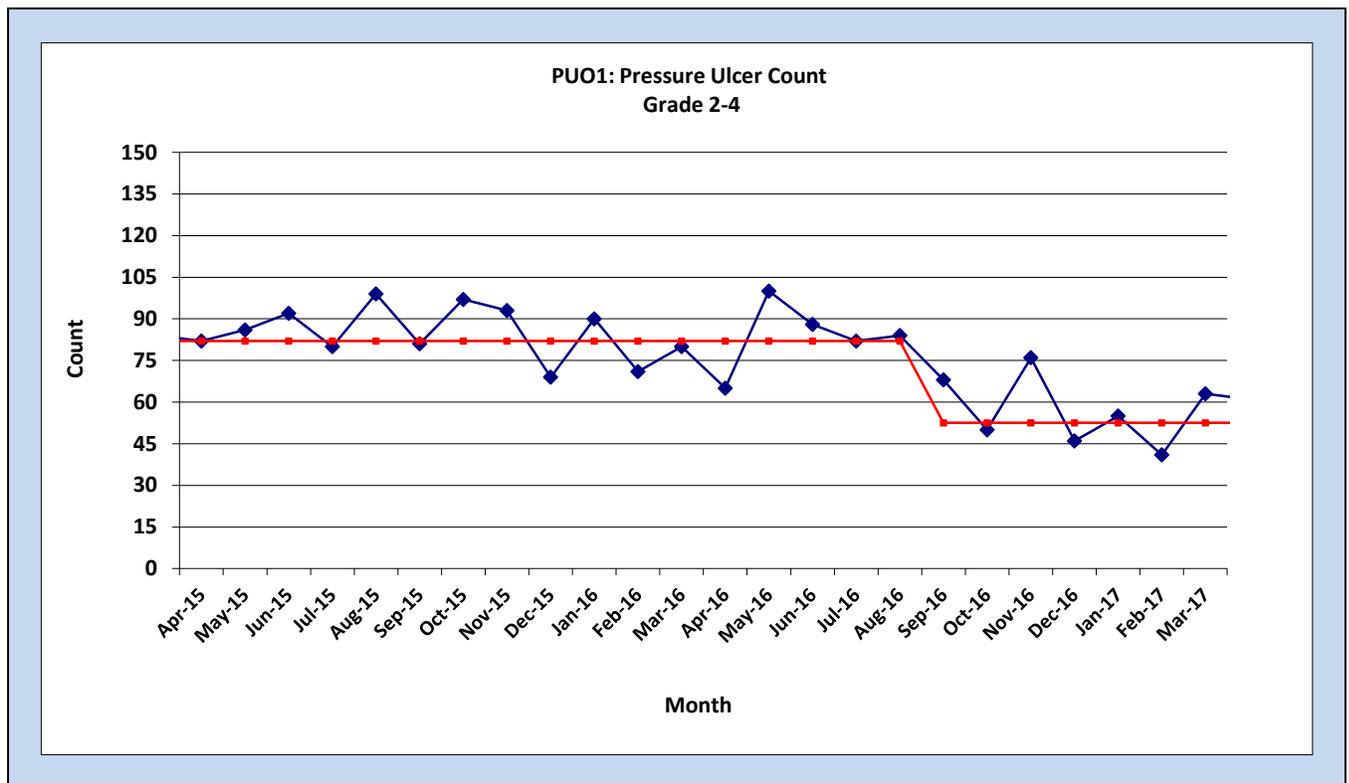
Following on from an initial assessment of barriers to reliability a successful brainstorming session with the team identified a number of tests of change for the ward. The successful changes have included:

- Introduction of a sticker for Structured Response developed by the ward team.
- A nominated nurse on each shift is responsible to care for the deteriorating patient as a first responder when they trigger a NEWS of five or more. This has been key to the success of the project again suggested by B2 team.
- An Acronym for the Beatson deteriorating patients to prompt staff to complete all elements.
- Education at ward level specifically on Structured Response.

The data collected was based on eight elements of Structured Response. This had been collected in B2 from January 2016. The monthly compliance to date has improved from 56% to 100% in April. This increase has seen a shift in the data changing the median from 53% to 82%.

### **Preventing Pressure Ulcers**

The Board has developed a clinical decision aid to of Pressure Ulcer Daily Risk Assessment (PUDRA), to evidence risk assessment and ongoing care planning. It is consistent with the main elements of the SPSP bundle and has been introduced to all clinical areas for acute adult services. Monitoring is through measuring outcomes via Datix and the following chart shows the benefit of this work in a significant reduction in the number of pressure ulcers from Autumn 2016.



### Physical Health Care Planning Quality Improvement Project

There is a growing body of evidence which clearly demonstrates that improving physical healthcare can enhance mental health and wellbeing. Baseline data collection in April 2016 within Jura Ward (Specialist Dementia Unit), Stobhill Hospital indicated that only 20% of patients had robust physical health care plans in place. Staff were keen to change this position and agreed to partake in a programme of work to improve physical health care planning for their patients.

Starting in July 2016 the aim was by May 2017, to have 95% of physical healthcare plans in place within 72 hours of admission. It was also agreed that these physical health care plans would be person centred and detail physical health interventions relating to individual needs.

Over a 36 week period an improvement has been observed from 20% to a median of 80%. The physical health care discussions at Multi-Disciplinary Team (MDT) meetings have shown most reliable improvement most commonly ranging from 70% to 100%. Currently the physical healthcare plans in place detail specific individual physical health needs recognising the range of complex physical conditions.

As part of this work staff have also captured their reflections on how they have developed a better understanding of physical healthcare planning. In addition, a local process for implementing care planning has recently been devised and testing of a new physical health care plan template. With a focus on meeting the overall 95% aim. Plans to test through PDSA the agreed care planning process, implement the new template and ask staff to describe how this physical healthcare activity is aiding patient care.

### **Interventional Radiology Theatre Utilisation Project**

Interventional Radiology were experiencing low theatre utilisation due to a high percentage of late starts/delays and in some instances cancellations in Interventional Radiology procedures most often due to patients not being ready when the list was ready to start. Some cancelled procedures were being placed on, and impacting on, the emergency list.

By using qualitative data obtained from stakeholders and the measuring and stratification of quantitative data a number of interventions including staff training, standardisation of processes and intranet development has seen the median increase from 74.5% to 92.5%. 6 individual months have shown no late starts/delays in procedures, 7 individual months have shown no cancellations in procedures thus reducing the impact on the emergency list. Agreement has been reached with stakeholders to start testing the implementation of an electronic pathology form.

### **To Reduce the Number of Unnecessary Ear Irrigations in Treatment Rooms Within the North-East Sector of Glasgow City HSCP by March 2017.**

Project was a part of the Band 5 Development Programme where a patient information leaflet was developed about how to oil ears in an attempt to reduce the incidence of unnecessary ear irrigation. The leaflet would also support patient education and self-management as well as release time for other interventions / consultations. However the main benefit to the project was to increase patient safety through oiling ears thereby avoiding irrigation. The pilot within all 7 Health Centre Treatment Rooms in North East Glasgow saw a 75% reduction in ear irrigation since March 2016 by providing patients referred for irrigation a leaflet and a short appointment with the nurse or Health Care Support Worker either face-to-face or by telephone to support the patient with oiling their ears. The learning from this project will now be used to spread this to other areas of Glasgow HSCP.

### **Community Diabetes Specialist Nurses (CDSN): Service Evaluation to Develop an Evidence Base for Professional Practice**

Changes in the structure of care delivery in primary care have prompted the necessity for a greater understanding of the CDSN role.

The results of the project reflect the complexities within which CDSN's are working and has contributed to the overall evaluation of their role. The data confirms that CDSNs receive referrals predominantly from GP's. They receive four times as many referrals from GP's as from secondary care or self- referrals. CDSN's also refer patients back to mainly GP's. There is a small number of referrals from Secondary Care Consultants and an even smaller number of referrals back to secondary care. This helps colleagues in acute settings to understand the level of complexity of care provided in the community setting and its potential to prevent admissions to acute settings. The report shows that CDSN's are often the last point of contact for complex patients.

The evaluation has been used to identify areas for professional development sessions.

### **Improving Risk Management at Key Points Within Transitions of Care (Mental Health, Addictions and Learning Disability Nursing)**

A Risk and Safety Interface Practice Development Nurse was appointed for one year to develop and deliver "Clinical Incident: Improving Outcomes"; a three hour awareness training session aimed at registered nurses within MH, LD and Alcohol and Drug Services to critically analyse the thematic and contributing factors within significant clinical incidents reports, provide evidence based literature to support learning and promote collaborative interface working to improve patient safety.

The evaluation showed improvement in levels of understanding evaluated post training with a mean overall increase of 37%, confirming that attending this training event has improved understanding of the themes, trends and contributory factors within significant clinical incidents and has raised awareness of evidence based guidance to implement routine interfacing practices between services at key points in transition of patient care.

It was evident from the replies received that there was an impact on practice, that staff understood risks and have started to implement risk reducing strategies in order to provide better outcomes for patients. It was encouraging to note the use of interface documentation especially as it was clear from the sessions that some staff were not previously aware of this document. Most importantly the sessions broke down barriers by giving staff an opportunity to meet and discuss the challenges together and gain an understanding of local issues and other perspectives. It was good to see that staff showed willingness to work together to promote safety at transitions of care.

### **Improving Monitoring of Side Effects Caused by Prescribed Antipsychotic and Mood Stabilising Medicines in East Renfrewshire Community Mental Health Team (CMHT)**

East Renfrewshire CMHT undertook a baseline analysis of medication monitoring services for people in the Levern Valley area who are prescribed antipsychotic and mood stabilising medicines. In summary, the 100% target was not achieved for any indices, and this was consistent across all aligned GP practices. Blood sugar monitoring occurred for 70% of cases audited; 56% of patients had lipids checked; 31% had electrocardiogram monitoring and only 15% had GGT monitoring. In addition to these audit findings, it was identified that mental health registers in GP surgeries did not match the patient population of the CMHT, which may have compounded the problem.

There are inconsistencies in how medication monitoring occurs across the CMHT Services and the Team will test changes to improve this in the future.

### **Standardising Sensory Workshops Across NHS GG&C Specialist Children's Services Occupational Therapy (OT) Services**

Using a combination of process mapping, driver diagrams and a staff survey, this project undertook to reduce referrals to Occupational Therapy Services for support with sensory issues. Following completion of initial scoping work the aim was revised to focus on shifting the balance of sensory work from specialist to targeted interventions on OT caseloads. This includes standardisation of the workshop model across all teams using small tests of change.

As part of a wider specialist assessment intervention, it is anticipated that more children will now receive targeted interventions, increasing specialist capacity on individual OT caseloads. This is being monitored through a small set of measures in each Specialist Children's Services Occupational Therapy Team.

### **Acute Oncology Service in the Queen Elizabeth University Hospital**

The Clinical Effectiveness team developed a measurement and recording system which enabled the service to quantify and understand the referral, presentation and management of patients with cancer and suspected cancer presenting unscheduled at QEUH. This data supported a clear need for oncology input into QEUH. Staff are now in place and the QEUH Acute Oncology Service is due to start with new nurses and doctors have been appointed.

The West of Scotland Cancer Group will now replicate the QEUH audit in GRI, RAH and Inverclyde. In addition Ayrshire and Arran HB, Forth Valley HB & Lanarkshire HB have all commenced using the database developed in NHS GG&C.

## **6. Conclusion**

In last year's report a broad set of development aims were outlined. These informed the broad scope of work that is described in the report. For instance there are examples of:

- Key improvement programmes for clinical safety and patient experience (aim to work at larger scale),
- Lessons generated and applied as a result of adverse events (aim to learn when things go wrong),
- Training of staff and development of their ability to apply quality improvement techniques (aim to develop QI skilled clinical teams),
- Effective use of data to visualise and confirm that improvement projects are effective in improving quality (aim to use information effectively),
- The production of clinical guidelines to ensure high quality clinical practice (aim to enable evidence based practice),
- Independent confirmation that the clinical governance arrangements are well embedded (aim to ensure robust support and monitoring),
- The use of external quality publications (aim to apply lessons from external sources),
- The monitoring of key programmes to enhance their effectiveness (aim to ensure effective progress).

As well as informing the work within the year the development aims were also the basis for a larger organisational debate about how we could become more effective at improving and sustaining quality of care. Following on from this the Chief Executive has set two corporate objectives which will further guide clinical governance within NHS GG&C, these are:

- Develop a Quality Strategy for the NHS Board, identifying key priorities and prepare an Implementation Plan.
- Review, update and implement the Clinical Governance Strategy for the NHS Board.

We plan to consolidate and integrate the work of last year into a more substantial vision for clinical governance within NHS Greater Glasgow and Clyde.

As described in the introductory section this report can only provide insight into a small sample of the overall clinical governance related activity within NHS Greater Glasgow and Clyde. From the information provided we have demonstrated the significant commitment of the Board staff to managing and improving the quality of care we provide. There remains an ongoing focus in continuously developing the process of systematic support and oversight to ensure robust recognition of issues and improvement. However we have shown, supported by independent monitoring, that the clinical governance structure is well developed, linking the Board to clinical teams and patients.