



# Clinical Governance Annual Report 2018-2019

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 to:

*“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 (NHSGGC) provide in connection with the prevention, diagnosis or treatment of illness. It includes services that are jointly provided with other organisations. Essentially NHSGGC must satisfy this duty of quality through internal arrangements, and also through effective collaboration with partner organisations.

The framework of arrangements 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 describing its clinical governance arrangements, and the progress it has made in improving safe, effective and person centred care.

This report presents a small selection of the activities and interventions, so is illustrative rather than comprehensive. It is important to note that there is substantially more activity at clinician, team, and service level arising from the shared commitment to provide high quality of care

## 2: Key achievements and examples of improvements

**2:1** Key achievements in 2018-19 are:

- A number of thematic reports have led to significant systems improvement, two examples are insulin safety and care of spinal injury patients (as mentioned in the body of the report).
- Ongoing support to key safety programmes within the Board
- Development of QI Capability within NHSGGC
- Maintenance of processes for clinical guidelines, and to track and review clinical quality publications
- Support to HSMR reviews
- Eight hundred and sixty-five (865) real-time care experience feedback conversations held across four sector/directorates.
- Aggregated positive care experience which ranges from 91 – 97% (median = 95%).
- Five thousand four hundred and thirty-five (5435) narratives (qualitative summaries) were collected. Of these, four thousand two hundred and four (4204 = 77%) had a positive tone, one thousand and seven (1007 = 19%) had a negative tone and two hundred and twenty-four had a neutral tone (224 = 4%) (Figure 4).

2.2 Some improvements to the quality of care as a result of this work are outlined below:

**Improvement example 1: Cue based feeding**

The aim of the project was to show that the level of inpatient days was either reduced or maintained following the implementation of cue based feeding at the Neonatal Unit (NNU) NNU by April 2019

Traditional Volume driven feeding was used in the NNU prior to the introduction of cue based feeding in October 2017.

Studies have shown that being guided by the infant’s cues allows the infant to set the pace that is right for their stage of development. This improves long-term neurodevelopmental outcomes for the most fragile of NICU babies, whilst promoting parental attachment and decrease parental anxiety (Shaker 2013). Results of the majority of the research describe the possibility of a decrease in length of stay and improvement in weight gain, without any negative outcomes (McCormick et al., 2010).

In October 2017 the Princess Royal Maternity Hospital (PRMH) NNU introduced a cue based 5 point scoring system to identify when to offer a suck feed, either breast or bottle, whilst recognising when the infant is displaying “stop” signs. These were displayed in the NNU and made visible to both staff and parents/carers.

Data was collected on all infants with a birth gestation of 30+0 to 35+6 who were admitted to the PRMH NNU

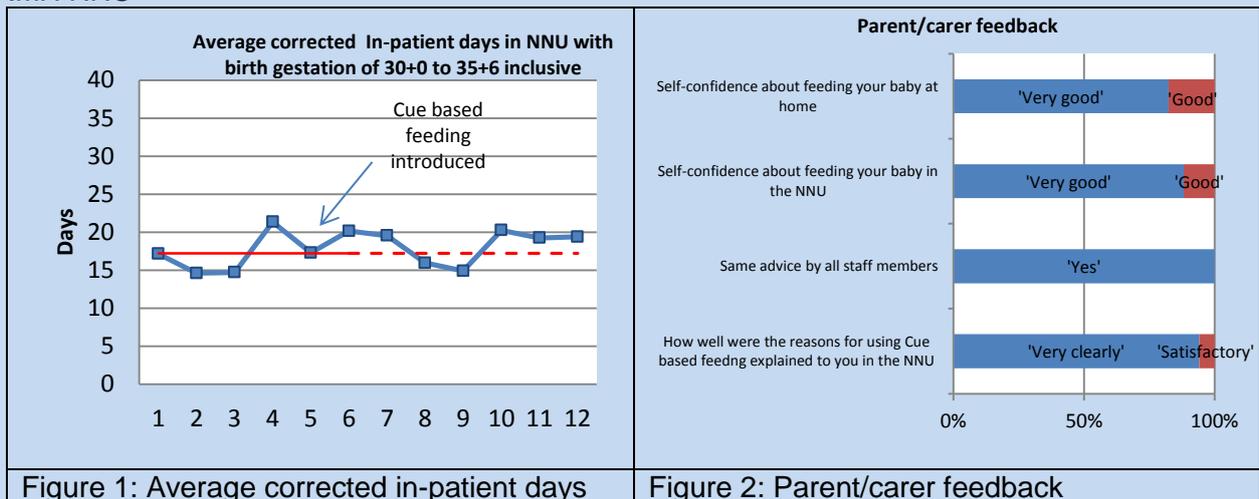


Figure 1: Average corrected in-patient days

Figure 2: Parent/carer feedback

The overwhelmingly positive parent/carer response, in conjunction with the staff feedback, shows that the implementation of cue based feeding has been highly successful.

However, there has been no demonstrable difference in either the length of stay on the unit or the length of time from 1<sup>st</sup> to full oral feed.

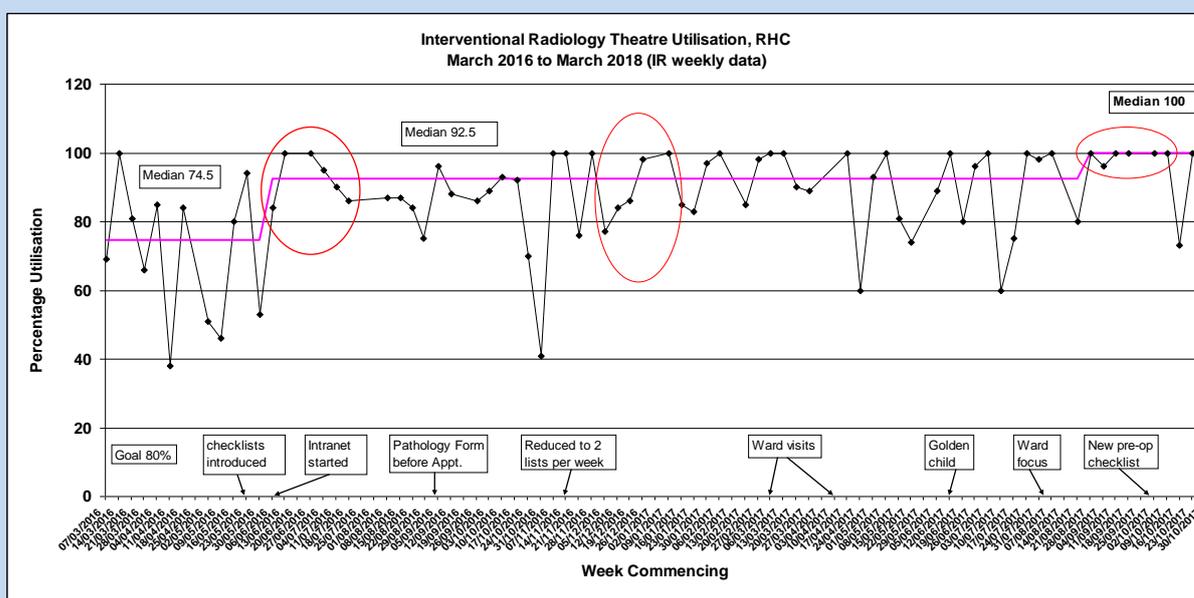
## Improvement example 2: Paediatric Interventional Radiology Theatre Utilisation

The aim of the project is to improve Interventional Radiology Theatre Utilisation for Children's Scheduled Procedures at The Royal Hospital for Children to 80% by 31/03/18.

A high percentage of 'late starts' or delays in Interventional Radiology procedures resulted in the utilisation of this area to fall into the bottom 25% category of teams within the Royal Hospital for Children. Lists were being cancelled by theatre management and most often were due to patients not being ready or properly prepared when the list was ready to start. This impacted on patient care as commonly children undergo an excessively prolonged period of fasting

Quantitative measures including outcome, process and balancing measures were agreed and used along with qualitative data, particularly in establishing reasons for delays and obtaining feedback from staff involved in tests of change.

Baseline data was available and data was collated on a weekly basis. Collation of data regarding late starts/delays to procedures was prioritised using a Pareto chart in relation to the reason for late starts/delays and for areas contributing to the impact caused by late starts/delays to procedures.



The overall aim of the project was achieved, with a median at the start of the project of 74.5%, and at the end of the project of 92.5% (February 2018). Other improvements shown by the project were:

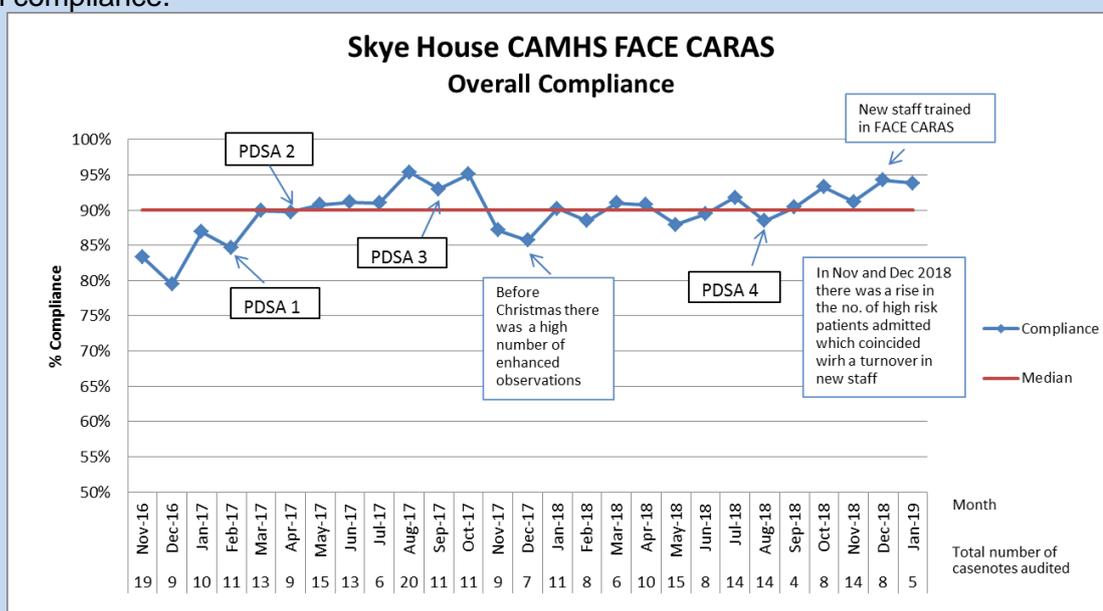
- Late session starts decreased by 10%
- Data revealed 11 months with no delays to procedures
- Data revealed 16 months with no cancelled procedures
- Impact on the Emergency List reduced
- Implementation of an Electronic Pathology Form

### **Improvement example 3: Child and Adolescent Mental Health Service (CAMHS)**

In 2016 Skye House, Glasgow Adolescent Inpatient Unit, recognised that there were issues with the completion of their risk assessment tool, FACE CARAS. They decided to take a quality improvement approach to improve the completion rates of relevant risk assessments for all patients admitted to Skye House. Their original aim was to achieve 100% compliance by June 2017 and this has been achieved and maintained for 10 out of 13 of the risk assessment schedules. The overall compliance is currently 94%.

These improved and maintained compliance rates have been achieved by means of quality improvement methodology including the use of PDSA (Plan, Do, Study, Act) cycles to test changes. The team lead analyses the compliance data monthly and shares this with the wider team to help them address any gaps. For example the team realised that it made sense for the vulnerability assessment schedule to be completed by case managers and as a result compliance has increased from 16% in Nov 2016 to 80% in Jan 2019.

The chart below provides a summary of some of the actions which have been taken to promote and maintain compliance.



- PDSA 1 – February 2017 Changed documentation for Early Care Plan and Review
- PDSA2 - April 2017 Sending feedback to named individual nurses to support completion of FACE CASH (Child and Adolescent Self Harm Schedule) assessments
- PDSA 3 – September 2017 Reviewed guidance to staff. Particular focus on CASH and VAS (Vulnerability Assessment Schedule).
- PDSA 4 – September 2018 MDT document revised to remind staff to answer schedules. The QI project lead met senior staff to agree who should complete each schedule, reviewed timescale for completion and updated and circulated this to all staff.

#### **Improvement Example 4– Ward 3, General Medical Ward, Glasgow Royal Infirmary, North Sector**

Professor McKay involved and discussed ward round communication with the wider medical team, and the expectations of communication within the ward for patients and visitors. At induction all new staff members, including nursing and medical now receive advice about their role and expectations of communication processes within the ward. Patients and relatives are now routinely asked if they have any questions during ward round discussions. If significant or confidential discussion is required with a patients and/or relatives, they are taken to the Quiet Room for privacy.

#### **Improvement Example 5: Ward 67, Neurology Ward, Queen Elizabeth University Hospital, Regional Services**

Care experience feedback identified that patients and relatives often had communication and information gaps, which on occasions nursing staff were not able to resolve immediately and affected the efficiency of how care and care planning was coordinated within the ward. On reflection, nursing staff were able to identify a gap in the multi-disciplinary communication process within the ward. They shared that frequently medical staff spoke to patients and/or relatives in the absence of nursing staff and did not always record the communication in the case record. To resolve the issue and improve communication they implemented a daily communication huddle between nursing and medical staff to provide updates on new developments and planned developments and changes to care to ensure accurate information is shared with patients and relatives throughout the day. Prior to the huddle commencing the nurse asks each patient if they have any questions or queries and returns to the patient following the huddle to provide an update and respond to any further questions and queries they have from the new information.

The aggregated experience for communication and involvement in care ranged from 94 – 100% from March 2018 – October 2018. Prior to improvement being implemented this ranged from 85 – 100%

*'I've had everything explained to me in the way I've needed as well as my concerns answered'*

*'There were five Consultants in this small room one day eliminating things that the symptoms I'm having could be related to almost like counting things in and out; it was fascinating to be part of. Most definitely, I was included in the assessment and the discussion all the way along. Despite it being about my progressive condition I was enthused by their approach to finding the best solution for my quality of life'*

### **Improvement Example 6 – Acute Assessment Unit, Glasgow Royal Infirmary, North Sector**

The feedback provided the opportunity for staff to reflect on the needs, requirements and preferences of people with a disability and the requirement to assess them on an individual basis to acknowledge what is important in their care and their specific support needs within the environment of care. Contact was made with the NHSGGC Equality and Human Rights Team to request a Disability Access Audit. This was conducted with assistance of two volunteer wheelchair users navigating the patient journey in Acute Adult Assessment (AAU) (one independent in wheelchair the other requiring to be pushed). Immediate small changes have been made to provide an allocated space in waiting areas for wheelchairs only. The Facilities and Management Team have a full report of work required for other environmental and practical adjustments requiring a budgetary decision. At time of writing, approval of suggested improvement actions requiring a facilities management decision as pending and have been followed-up.

*'A&E sent me to AAU, I am in a wheelchair so once I got to the main entrance of AAU, I couldn't reach the buzzer to gain access to the unit - it is too high. So I had to go back out to A&E and get a member of staff to press the buzzer to AAU and let me in.'*

### **Improvement Example 7 – Older Peoples Wards, Glasgow Royal Infirmary, North Sector**

People with visual impairment or other sensory impairment were identified at the beginning of each shift as part of the safety briefing. Catering and facilities staff was advised of patients with sensory impairment via the mealtime communication board in the kitchen, and what their specific needs are.

*'I don't need assistance with eating and drinking as such. What is a problem is that things are placed on the table and the table not moved close to me so I end up having to feel around to find the table and then what is on it. The people who give out the tea are the worst. You probably noticed just then... she put down my coffee and biscuits on the table but I can't reach it.'* (Patient has impaired vision)

### **Improvement Example 8 – Ward 23, Orthopaedics, Royal Alexandra Hospital, Clyde Sector**

Nursing staff tested out offering a therapy doll to a (female) patient to relieve distress. The use of dolls can bring great benefit to some people with a diagnosis of dementia, particularly those in later stages. It involves making a doll available to the person to hold or to sit with. Some people with dementia find that they get enjoyment from holding or simply being with a doll. It might remind them of a time when they had young children of their own or simply create pleasant feelings of reminiscence or affection. Some family members find that giving the person they care for a doll seems to inspire a renewed sense of purpose, which can lead to increased activity levels and liveliness. The staff discussed the advantages of introducing the doll with the family, and addressed any potential controversy around the idea, explaining the benefits of a helpful non-drug way to calm individuals and the benefits of providing the comfort of cuddling a soft life like baby doll. Having a doll to interact with can improve the person's communication, which can produce improvements in communication with other people. This had an almost immediate effect of calming the patient every time the doll was introduced and they remained calm when cradling the therapy doll. The ward explored further ways to offer similar comfort and found a local volunteer group who make and provide single use 'twiddle mats' and 'muffs'. These are effective in a similar way to therapy dolls using knitted mats with interesting bits-n-bobs attached, designed to provide simple stimulation for active hands and promoting hand coordination and flexibility. These approaches have helped calm and reduce distress in older adults with severe agitation or other behavioral challenges and reduced the need for medication and on occasion the withdrawal of constant enhanced supervision. Seeing their relative less distressed and agitated has also eased the worry and anxiety for family and provided reassurance that their relative is being care far safely when they are not present.



### **Improvement Case Study 9: Weekly Integrated System Response (WISeR), Renfrewshire Health and Social Care Partnership (HSCP)**

An elderly gentleman, Mr X, with a history of upper gastro intestinal tract cancer was referred to WISeR in December 2018. He lived with his wife. Mr X had stopped treatment for his cancer in February 2018 and had been experiencing ongoing problems with fluid building up in his abdomen. His GP was aware of ongoing changes and problems that Mr X was experiencing and referred him to WISeR for care coordination. WISeR coordinated the care for a total of 16 weeks. On referral Mr X was not linked in with any community services and the team agreed that the Rehabilitation and Enablement Service nurse would be the lead service. At the WISeR weekly updates it was clear that Mr and Mrs X needs were complex and required support and intervention from multiple services. From analysis of recorded observation of the weekly MDT discussions and sharing of information about Mr X care.

The following themes emerged:

**Increasing burden of illness**

Week on week Mr X was experiencing a persistent increase in symptoms and frailty as a result of his disease. It was clear he was striving to hold on to his independence and mobility. He was still getting out with help from his family at week 8.

**Care Coordination- Multiple services providing care**

GP, RES (Nurse, OT, Physio, Dietician), Community Nurses, Palliative care clinical nurse specialist, Care at Home, Advice Works were all involved. Through WISeR they coordinated visits, shared information and planned ahead together. They also coordinated their response to providing care when the family expressed feelings of being overwhelmed by services.

**Complex care**

Weeks when discussed and documented

Equipment Anticipatory

3,5,7,8,9,1, 5

Care Planning

3,6,8,9,14

Carer Support

3,5,6,7

Finances

4, 8, 6

Admission to RAH for procedure to increase comfort

4,8,6 6,11,12

**“Seeing it coming”**

Services were recognising and responding to increasing burden of illness and frailty and planning ahead with each other and Mr and Mrs X.

**Person centred care Supporting growing acceptance**

Staff were walking along side this family supporting their growing acceptance of care, support, equipment, services and ultimately of dying.

The evidence was clear that services were working together and responding to Mr Xs changing needs and those of his wife. There were times when the family felt overwhelmed by the number of services involved and increasing frequency of visits, services responded to this by coordinating visits and sharing important updates through WISeR. Equally there was lots of evidence of going at the families pace, offering guidance and planning ahead but being person centred and respecting Mr and Mrs X as decision makers about care. There is documented evidence of offering additional care, services and equipment as part of ongoing and evolving Anticipatory care conversations, alongside documented evidence that these things were only put in place when the person and their family were ready to accept them. When Mr X died, he was peaceful and at home with his wife, where he wanted to be.

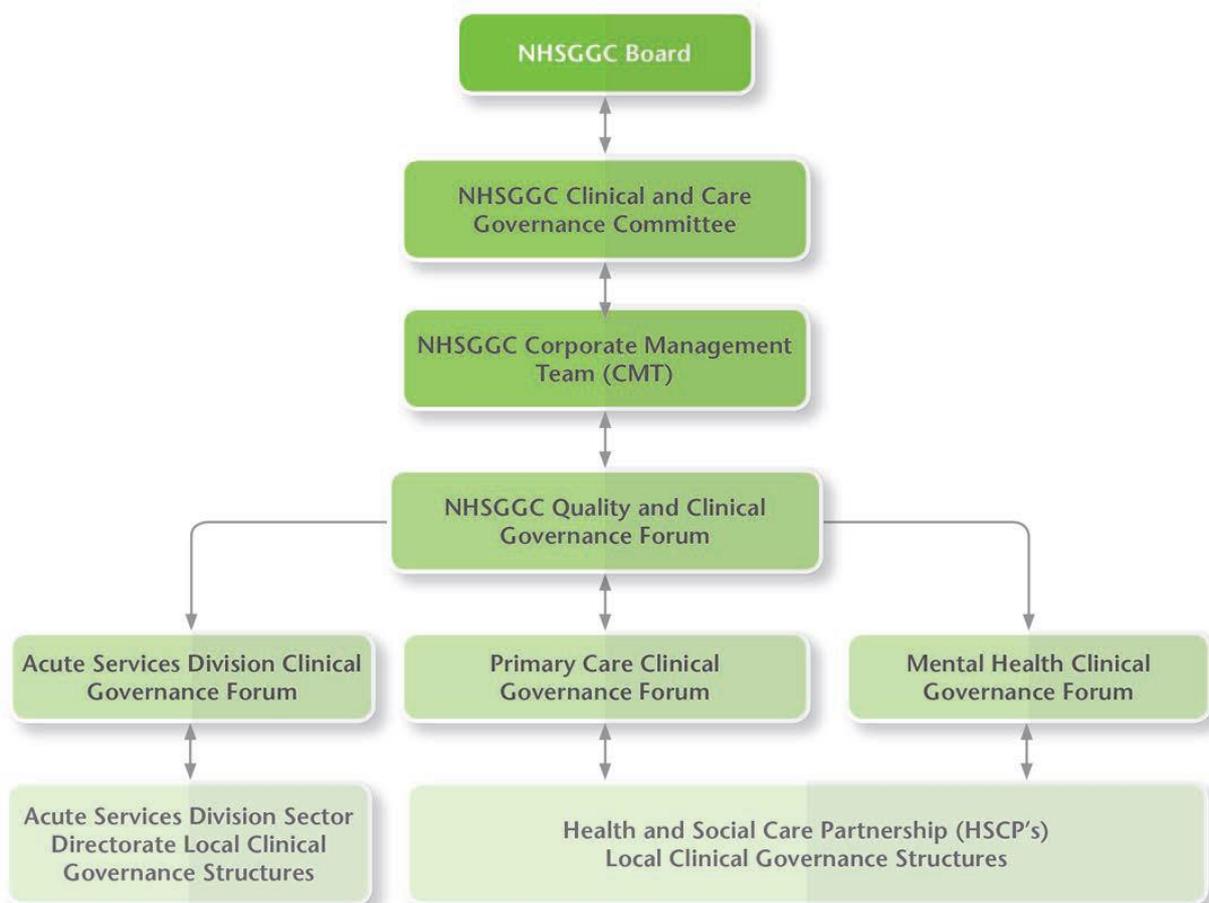
### 3: Clinical Governance Arrangements

#### NHS Greater Glasgow and Clyde's purpose is to:

"Deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities."

NHS Greater Glasgow and Clyde (NHSGGC) is one of 14 regional NHS Boards in Scotland. The Board provides strategic leadership and performance management for the entire local NHS system in the Greater Glasgow and Clyde area and ensures that services are delivered effectively and efficiently. Responsible for the provision and management of the whole range of health services in this area including hospitals and General Practice, NHSGGC works alongside partnership organisations including Local Authorities and the voluntary sector. NHSGGC serves a population of 1.14 million and employs around 39,000 staff – it is the largest NHS organisation in Scotland and one of the largest in the UK.

- 3:1** The current healthcare governance arrangements consist of a Clinical and Care Governance Committee which is a standing sub-committee of the main Board and is led by Non-Executive Board members who take an overview of healthcare quality and clinical governance. The role of the non executive Board members is to seek assurance that NHSGGC have formal arrangements that work effectively to safeguard patients and to continually improve the quality of care we provide.



**3:2** The Board Nurse Director is the Executive Lead for Healthcare Quality Strategy and Board Medical Director is the Executive Lead for Clinical Governance. The Clinical and Care Governance Committee receives reports from the key service areas as well as a range of thematic reports on issues relating to feedback and complaints, the wider patient and carer experience perspective, 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.

Health and Social Care Partnerships (HSCP's), Acute Sectors and Directorates have their own Quality and Clinical Governance Forums, which are in turn linked with other groups at specialty and sub-specialty level. This broad network provides significant opportunity for local teams and managers to contribute to the agenda. The Board uses Internal Audit as a means of independently checking the effectiveness of all these arrangements.

### **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)
- 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 Service

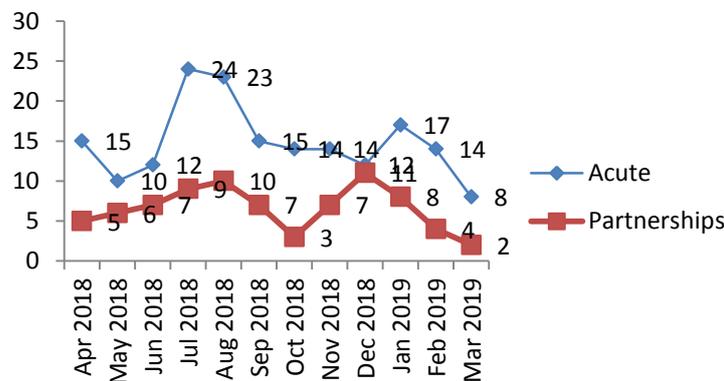
## 4: Patient Safety and Clinical Risk Management

### 4A: Clinical Risk Management

#### 4A.1: Significant Clinical Incidents (SCIs)

From April 2018 to March 2019, a total of 297 clinical incidents were escalated to SCI status, which is a decrease of 31 events from the previous year (Acute - 178, Partnership - 79).

#### No of SCIs each month (April 18 - Mar 19)



Quarterly reports on SCIs are prepared for the Acute and Partnership Clinical Governance Forums to provide an overview of trends, themes, learning and action taken following SCIs.

#### 4A.2 Level 4/5 Process

The last policy review included a summary of the severity 4/5 process. This screening tool ensures that those incidents for that do not progress as a Significant Clinical Incident there is a formal record of the review undertaken to inform this decision making.

#### 4A.3 Recommendations and Action Plans from Individual SCIs

All recommendations from significant clinical incidents are logged onto the Datix Actions module. This allows an automatic email to those responsible for taking the action forward.

Below are a number of examples of closed actions from significant clinical incident reviews which occurred between 1<sup>st</sup> April 2018 and 31<sup>st</sup> March 2019.

- A change of practice within gastroenterology means that prior to infusion of fernject (an intravenous (IV) iron preparation) a normal saline flush will be performed to ensure potency of cannula; after the infusion another flush will be carried out to ensure no traces of iron remain in the cannula. It is also now practice that IV infusion pumps will not be used for the delivery of fernject.
- Following a significant clinical incident relating to medication omission there were a number of recommendations relating to reviewing stock of licensed products and checking process for missed doses on the ward. A pharmacy support post was created and recruited to as a means of supporting this process.
- Following a significant clinical incident relating to an immediate discharge letter (IDL) including medication that should not have been included a number of recommendations were made. This included that a walkthrough of the IDL process should take place. A process map has since been developed and agreed with input from pharmacy colleagues. This process map is available in each ward.
- NHSGGC Podiatry, as a single system service hosted in Renfrewshire, reviewed its systems and processes for referral of foot wounds. As a result of one SCI, the podiatry service implemented a review of Foot Protection referral mechanisms across NHSGGC and developed a marketing campaign to educate and inform all Health and Social Care Partnerships (HSCPs) across the service about referral into the service.
- A significant clinical incident review was undertaken following an infant child presenting to the RHC with abusive head trauma and had been admitted to the RHC on five separate occasions prior to this presentation. The review team made recommendations including enhancing child protection training and that there should be one point of contact for accessing the NHSGGC Child Protection Service for health staff requiring advice and support in relation to child protection. The Child Protection Services now has a single point of contact and staff were briefed by email so the action is complete for health services. The brief was included within the staff core brief system which is available via the intranet pages. The brief also reminded health staff that all Notifications of Concerns submitted to Social Work department should be electronically shared with the child protection service.

#### 4A:4 Thematic Analysis

There was recognition that there would be organisational benefit in performing more thematic analysis of significant adverse events. Thematic analysis has taken place within the following areas: Suicide reviews, Medication administration errors, CTG interpretation (Cardiotocograph tracing of a fetal heart in utero), Spinal Fracture and Learning Disabilities.

#### 4A:5 Avoiding Serious Adverse Events Monitoring (ASEM)

The Board has a list of events that are considered avoidable due to the systems and processes in place to prevent known risks. In NHSGGC these are called ASEM events however some organisations call them Sentinel or 'Never Events'. The table below demonstrates the ASEM events reported over the past year. All of these incidents are investigated as SCIs. This is a decrease of 15 events from the previous year. There are 5 less medication incidents that meet the ASEM criteria this year.

Death or serious harm related to the use/ function of a device	1
local anaesthetic performed on wrong body part	4
medication error	9

NG Tube Misplacement	1
retained item	4
surgery performed on wrong patient/ wrong surgical procedure	1

#### 4A:6 Training and Education for Patient Safety

Education and training continue to be a significant component of the activity in Clinical Risk. In this past year several sessions have been delivered on the following topics:

- SCI investigation, Root Cause Analysis
- Human Factors in Healthcare
- Duty of Candour Disclosure training
- Duty of Candour update sessions

#### 4B: Duty of Candour

**4B:1** NHS Greater Glasgow and Clyde maintain a policy of “being open” when patients are affected by serious adverse events. The Management of Significant Clinical Incident (SCI) Policy states that communicating effectively with patients and/or their relatives is an essential part of the SCI process.

Between 1 April 2018 and 31 March 2019 there were 297 SCIs reported. It can take time to thoroughly investigate each event so at the time of reporting 125 of these root cause analysis investigations were completed. One of the main aims of performing a root cause analysis following an incident is to determine if the event was in fact avoidable, which helps decide and prioritise what may be done to prevent recurrence. It is also helpful to establish the relationship between the practice and the result i.e. did the action or omission in the incident cause patient harm or the event to occur?

To help us further define and categorise this information we use investigation outcome codes. They describe an option from 1 to 4 with the responsibility for causation increasing with the value of the number. It is important to note that not all SCIs investigated are avoidable and in some instances it is not until the end of the investigation that this can be concluded.

It must also be remembered that these levels do not directly relate to the harm to patients so for example an investigation outcome 4 could also have an unharmed or fully recovered patient. An example could be a scope which has not been complete adherence to decontamination procedures – we would regard this as a serious failing, which should not occur, however it is unlikely the patient will have been harmed from this.

#### Investigation Outcome

- Appropriate care: well planned and delivered
- Issues identified but they did not contribute to the event
- Issues identified which may have caused or contributed to the event
- Issues identified that directly related to the cause of the event

Of the 125 investigations completed 108 (86%) patients/relatives were informed and invited to participate in the investigation. We review and record where the patient was not informed. The reasons for not involving included events where disclosure was deemed to cause harm or the investigation relates to an internal process unrelated to the patient outcome.

## 4B:2 Background

On 1<sup>st</sup> April 2018 the Duty of Candour Procedure (Scotland) Regulations came into force. All health and social care services in Scotland have a duty of candour. This is a legal requirement which means that when unintended or unexpected events happen, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

NHS Greater Glasgow and Clyde identify through a significant adverse event review process if there were factors that may have caused or contributed to the event, which helps identify duty of candour incidents.

There have been additional codes added to the electronic incident reporting system (Datix) to allow an annual report to be created for Duty of Candour events. The compliance with Duty of Candour will be monitored via the Clinical Risk reports that are submitted to the Acute & Partnership Clinical Governance Forums.

## 4B:3 How many incidents happened to which the duty of candour applies?

Between 1 April 2018 and 31 March 2019 there were 59 incidents where the duty of candour applied. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

Type of unexpected or unintended incident	Number of times this happened
A person died	10
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A persons treatment increased	36
The structure of a person's body changed	1
A person's life expectancy shortened	1
A persons sensory, motor, or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	6
A person needed health treatment in order to prevent them dying	5
A person needing health treatment in order to prevent other injuries as listed above	0
Total	59

## 4B:4 To what extent did NHS GG&C follows the duty of candour procedure?

A Significant Clinical Incident (SCI) investigation has been commissioned for all 59 Duty of Candour incidents. At the time of writing, 51 of these investigations have concluded.

Of the 51 concluded investigations all patients/relatives were informed and offered an apology. Patients/relatives were asked to contribute in all 51 investigations and offered the results of the investigation.

#### **4B:5 Information about policies and procedures**

In April 2018 NHS Greater Glasgow and Clyde approved and implemented a new Duty of Candour Policy which contains guidance to assist staff to comply with the legislative framework. There is also Duty of Candour information on the internal intranet site (Staff Net) which contains additional guidance and links to training opportunities including a virtual module (Learnpro) and face to face disclosure training.

Every adverse event is reported through our local reporting system as set out in our Incident Management Policy. Through our adverse event management process we can identify incidents that trigger the duty of candour procedure. Our Incident Management Policy and Management of Significant Clinical Incident Policy contain a section on implementing the duty of candour.

All staff receive training on adverse event management and implementation of the duty of candour as part of their induction, so that they understand when it applies and how to trigger the duty. Additional training is also available for those members of staff who frequently review adverse events, and for those who are regular key points of contact with people who have been affected by an adverse event.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure as well as through occupational welfare. This means that staff can contact a confidential telephone line to speak to trained counsellors.

#### **4B:6 What has changed as a result?**

There have been a number of changes following review of the duty of candour events. There are three significant changes to highlight:

- Following a significant incident relating to misplacement of a nasogastric tube, the critical care addendum was adapted and implemented to include additional safety recommendations with regard confirmatory chest x-rays.
- Following a significant clinical incident relating to medication omission there were a number of recommendations relating to reviewing stock of licensed products and checking process for missed doses on the ward. A pharmacy support post was created and recruited to as a means of supporting this process.
- Following a significant clinical incident relating to an Immediate Discharge Letter (IDL) including medication that should not have been included a number of recommendations were made. This included that a walkthrough of the IDL process should take place. A process map has since been developed and agreed with input from pharmacy colleagues. This process map is available in each ward.

## **4C: Datix**

**4C.1** Datix is the NHSGGC Incident Management System. During 2018-2019 key areas of focus have related to the contract renewal and procurement, infrastructure developments, changes to the adverse event module, changes to the contacts module, and team support.

### **4C:2 Contract Renewal and Procurement**

The current Datix contract was extended until May 2019. To comply with public sector procurement legislation NHSGGC now have a requirement to go to the market for other potential software solutions which may provide cost savings and better value to the organisation. A SLWG has been established to undertake this process.

### **4C:3 Datix Infrastructure/Developments and System Modules**

#### **PALS Module: Morbidity and Mortality (M&M) Project – Acute**

A suite of tools were developed and are available for M&M teams to improve the quality of their meetings, the engagement of the members, the learning from the cases discussed and the ability to assess their alignment with the guidance, which identifies good practice. The team continues to engage with M&M teams to identify and capture their specific requirements for bespoke data capture relevant to each individual specialty. In 2018 the tools were rolled out successfully to the following M&M teams.

- Surgery – Major Trauma
- Medicine – Cardiology
- General Surgery – Clyde Sector
- Emergency Medicine
- Medicine – Stroke

#### **PALS Module: Learning from Excellence Project – Acute**

A pilot 'Learning from Excellence' project was delivered in three areas of the Royal Hospital for Children during 2017/2018. The pilot was evaluated and presented to the Datix Governance Group. It was recognized that the project had significant benefits to staff morale and opportunities for learning from cases of excellent care. Governance approval was granted to roll out the Learning from Excellence Datix form to the entire Royal Hospital for Children and Specialist Children's Services and this was completed in early 2019.

### **4C:4 Incident Adverse Event module: Significant changes**

The following significant changes have been made to the incident adverse event module:

**2222 call/ cardiac arrest** - From 1<sup>st</sup> November 2018, cardiac arrests in NHSGGC are to be recorded as clinical incidents on the Datix Incident Management module. A new category of incident “2222 call/ cardiac arrest” was created to support this development.

**Pressure Ulcer Reporting** - The team worked closely with Tissue Viability and Podiatry colleagues to agree an updated dataset, to reflect additional information required to support the service delivery of foot and ankle pressure damage care.

**Violence and Aggression Reporting** - changes were made to the violence and aggression dataset for capturing incidents of hate crime within the board.

**MRI Safety Reporting** - The team has also engaged with the boards appointed MRI Safety experts and diagnostic colleagues to agree on a new dataset to facilitate better quality reporting of MRI safety incidents.

#### **4C:5 Contacts Module**

##### **Contact Matching and Interface**

Datix functionality currently relies on end users matching patient and employee contact details, which has created a known issue with multiple duplicate records.

There is a built in system process which allows administrators to link contact records which meet certain matching criteria. To support this, the team are now provided with a monthly download of data which is held in the GAL (Global Address List). Testing of the matching process to link duplicate employee contact records was commenced in the first quarter of 2019.

The team have also engaged with NHSGGC's Safe Haven department. A download of the patient demographic information held in Datix was provided to the Safe Haven Department and a CHI seeding exercise was carried out on the data.

Initial testing at the time of writing indicates this work, if approved by the appropriate governance structures, would have a positive impact on the data quality of both employee and patient records. Previous discussions with Datix and eHealth colleagues which looked at options of implementing an interface to other applications for example; SCI Store to import demographic data and Empower or eESS for employee records stalled due to other eHealth priorities. The outcome of the procurement will determine whether this requires to be revisited.

#### **4C:6 Team support performance**

The Risk Systems team continues to provide end users with an application support function.

- Support requests: The volume of support requests has reduced slightly year on year and this can be attributed to a number of factors including.
- Transformation of the training delivery model: This has changed from a labour intensive classroom training model to an online model with the development of comprehensive LearnPro modules
- Increased system functionality: to allow end users to perform simple admin tasks: End users can now reset forgotten passwords, redirect incidents which have been miscoded and come to them in error and add in additional staff to investigate incidents.

## **5: Effective Care: Quality Improvement and Corporate Assurance**

### **5:1 Revised arrangements for clinical effectiveness**

During 2018-2019 revised arrangements for CGSU roles and functions were implemented within the clinical effectiveness team, which resulted in a change in focus and management arrangements for the staff. This aligned staff to 3 key portfolios of work: quality improvement, evaluation and learning, and clinical informatics and reporting.

### **5:2 Support to Safety Programme(s)**

NHSGGC has continued to support the Scottish Patient Safety Programme, working on the acute adult, primary care and mental health programmes. Active work continues in the following work streams, with a high level summary of progress below:

#### **Acute Adult Programme**

##### **Acute Adult: Deteriorating Patient:**

From 1<sup>st</sup> November 2018, cardiac arrests (in NHSGGC were recorded as clinical incidents on the Datix Incident Management module. A monthly cardiac arrest report is now in place, which provides a cardiac arrest figure, and also monitors how well the cardiac arrest review processes are embedding.

In December 2019, the Deteriorating Patient Steering Group endorsed the move to an exemplar ward model. Each sector/ directorate will nominate a number of exemplar/ pilot wards for the programme. The exemplar wards will monitor progress in relation to the agreed outcome measure for the programme (cardiac arrests, which will be available via Datix). Improvement work will be centred around the 2 main aspects of deterioration: 1) processes to recognise deterioration (likely to consist of NEWS) and 2) recognition of deterioration. There will be a partnership approach to agree relevant measures for the active wards, which will consist of the service, clinical team and staff from the Clinical Governance Support Unit.

##### **Acute Adult: Other work streams**

From 1<sup>st</sup> December 2018, the improvement support model for the VTE and Sepsis programme was redirected, and the focus has now moved to embedding a quality management approach, and reporting key outcome measures.

#### **Primary Care Programme**

##### **Primary Care: Disease Modifying Anti Rheumatic Drugs (DMARDs):**

Participating practices have used their care bundle performance data to identify areas for improvement and make changes to their systems and processes with regards to prescribing and monitoring, resulting in an increased quality of care delivery for this cohort of patients.

##### **Care Connections – Red Bag Initiative**

The Care Connections – Red Bag initiative is part of the wider work of Glasgow City HSCP focusing on unscheduled care. A pilot began in July/August 2018 with 22 care homes located in the south of the in Glasgow City HSCP. Care home staff were supported to review their processes for unscheduled attendances to acute hospitals for their residents and to introduce the red bag and checklist document into their existing process and/or develop a standardised process. The team collected feedback and checklists from the care homes from September 2018 onwards. The project was rolled out across the whole Glasgow City HSCP and to the 5 other HSCPs during November/December 2018. The project is still in the early stages of change but is already demonstrating a positive impact as the data provided via

the care home dashboard indicates that hospital attendances are reducing and feedback from care home and acute staff has been overwhelmingly positive. The use of red bags once fully integrated, will facilitate a robust process to share information at key transitions between primary and secondary care settings

### **Mental Health Programme**

The SPSP Mental Health programme commenced in 2012, with the aim to improve clinical quality across all aspects of Mental Health services within NHS GGC by 2020. The CGSU has been involved in five main work-streams:

#### **Risk Assessment and Safety Planning**

To date there have been three sustained step-wise improvements in the wards' Risk Assessment bundle median process reliability, with 95% process reliability sustained since June 2018.

#### **Safe and Effective Medicines Management**

There have been two sustained step-wise improvements in the wards' Safer Medicines (PRN) bundle median process reliability, with 96% process reliability sustained since November 2017 through 2018. Stickers for 'as required' medicines, which were in use in all adult acute wards, have in many wards now been replaced by an equivalent EMIS electronic template, which improves ease of PRN recording and reference.

#### **Communication at Transition**

This work-stream focuses on the correct process for patient discharge, including follow-up within 7 days. There has been a sustained improvement in the wards' Communication at Transition bundle median process reliability, with 96% process reliability sustained since July 2017 through 2018. Wards' data collection for the Risk, Medicines, and Communication at Discharge bundles has been 'stepped down' to quarterly from May 2019.

#### **Violence and Restraint Reduction**

A revised Restraint bundle was introduced in July 2017. Eight wards, including the four IPCUs, are currently involved in this work stream.

There has been a sustained improvement in the wards' Restraint bundle median process reliability, with 89% reliability since June 2018.

The Intensive Psychiatric Care Unit (IPCU) network has continued to meet through 2018/19 with a key piece of work being the development of a debrief tool to use following a restraint.

#### **Leadership and Culture**

This work stream involves all 15 wards currently in the main SPSP MH programme. The key components are:

- Annual Staff Safety Climate Survey  
193 staff members responded in 2018. Resulting improvement action recorded by wards included: improving the safety learning culture on the ward; reintroducing staff meetings to improve visibility of new line managers; encouraging all staff members including senior managers to attend daily Safety Huddle.
- Annual Patient Safety Climate Survey  
68 patients responded in 2018. Resulting improvement action recorded by wards included: placing a statement about patient medication information in the Patient Welcome Pack; using Patient Community Meetings to increase patient awareness about medication information; clearly documenting patient preference with regard to information about their medication.

The Patient Survey was revised by Health Care Improvement Scotland in 2018 to include more demographic equalities data.

- Ward Safety Conversations (formerly known as Leadership Walk Rounds). These were re-started in October 2018, with 4 scheduled for 2019. Improvement actions for ward staff and visiting team are recorded and followed up.

### 5:3 Quality Improvement Capability

NHSGGC continues to support staff to develop the necessary knowledge and skills to carry out ongoing quality improvement initiatives.

In terms of national training, current numbers for NHSGGC staff are as follows:

- Scottish Coaching and Leading for Improvement Programme: 54 staff
- Members of Q Community: 30 staff
- IHI Improvement Advisors: 4 staff
- Scottish Improvement Leaders: 31 staff
- Scottish Quality and Safety Fellowship: 31 staff

NHSGGC have also taken forward a Clinical Quality Improvement Network (CQIN), which has been developed to learn and enhance applied Quality Improvement practice across NHSGGC, to learn about effective network behaviours and use these to develop CQIN further. A twitter account has been progressed to promote the network.

#### **NHSGGC Scottish Coaching and Leading for Improvement Programme (SCLIP)**

The Scottish Coaching and Leading for Improvement programme (SCLIP) is a Quality Improvement learning programme. The target audience for the programme is core managers who are responsible for coaching and leading their teams to improve their services and helping embed improvement strategies within their organisation.

The aim of the SCLIP programme is to develop individuals who will coach and facilitate teams to deliver improvement and to support achievement of improvement strategies within their organisation.

NHSGGC, working in conjunction with NES, began delivering a local cohort of SCLIP in February 2019. There are 35 participants from across NHSGGC and the six HSCPs in the board area. The programme is due to be completed in May 2019 and a further cohort is planned for later in 2019.

#### **NHSGGC Quality Improvement Training**

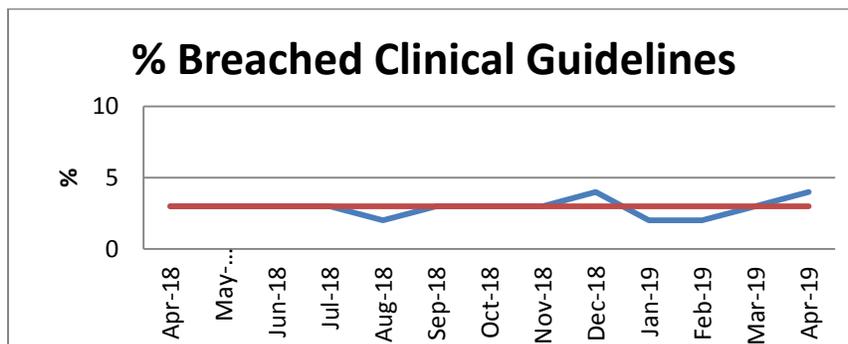
Since 2014, 47 1-Day Quality Improvement Workshops have been held, with a total of 1085 delegates attending 47 sessions.

A survey was sent out after each work shop, and is used to measure the impact of the training on knowledge of quality improvement skills, methods and tools included in the programme of the workshop. To do this, delegates are asked to rank themselves against 19 QI skills, methods and tools, as well as provide feedback on the event itself. QI Delegates are also offered the opportunity to work with a Quality Improvement Coach, which has been in place since January 2016. The last one day QI workshop was held in January 2019, and the evaluation will be used to inform a QI Capability Framework for NHSGGC

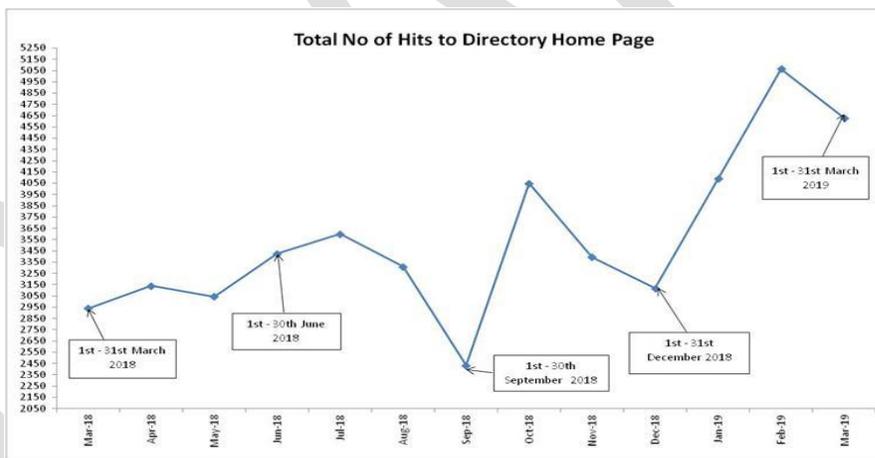
## 5:4 Clinical Guideline Framework

Processes to support the implementation of the NHSGGC Clinical Guideline framework continue to operate well; with the directory and home page continuing to be well utilised resources.

There are currently 540 clinical guidelines posted on the Clinical Guideline Directory, of which 519 (96%) are current and valid. The percentage of breached guidelines has consistently remained under 5% since July 2017. A key achievement this year has been the migration of Obstetric clinical guidelines to the Clinical Guideline, which is now complete.



The total number of hits to Clinical Guideline Directory Homepage at March 2019 was 4629



## 5:5 Framework for clinical quality publications

The NHSGGC Framework for Addressing Clinical Quality Publications was approved at the Board Clinical Governance Forum in September 2018. The framework ensures that the Board is aware of the most recent clinical quality publications; provides assurance that the current position in relation to publications is known; and that any actions in response to the publication can be agreed. Processes to track and review clinical quality publications, and to review national guidance and NICE IPGs, continue to operate well. Between 1<sup>st</sup> April 2018 and 31<sup>st</sup> March 2019, 86 clinical quality publications were identified for tracking.

CQPs	23
Cancer publications	12
National guidelines	5
HIS Standards	4
SHTG advice	6
NICE IPG	36

In December 2018, the CGSU Corporate team were asked to develop processes to “red flag” either identified reports/ publications, or specific actions identified following the review of a publication, to monitor and provide assurance of progress. A high risk rating can be applied where the nature of any outliers, or of any outstanding actions or recommendations, are considered a high clinical risk, or where they constitute a risk to the reputation of NHS GGC. There are currently 3 red flag items which are being tracked.

## 5:6 Data and Analytics

### Data support to SPSP

The Clinical Effectiveness Team provides data management, collation and reporting support to the Scottish Patient Safety Programme (SPSP) workstreams. Measurement data is used both at local front-line team level and aggregated to Site, Directorate/Sector/HSCP, Acute/Primary Care level, and for national reporting and oversight.

During 2018/2019 a stock-take of the current SPSP measures supported by the team was undertaken. At February 2019, the CGSU data team actively supported 41 SPSP measures. It is anticipated that 18 measures will no longer be required going forward, due to overall changes in the programmes of work, or measurement plan; leaving 23 measures which will require ongoing support.

### Core Audits

The team also provides on-going support for Core Audits across Primary Care and Mental Health. The Core Audit Schedule was developed as a systematic approach to defining, monitoring and assuring quality care across primary care and mental health services of NHS Greater Glasgow and Clyde. The audit has applicability across all disciplines and partner agencies.

### Hospital Standardised Mortality Ratio (HSMR)

Information Services Division (ISD) releases the Hospital Standardised Mortality Ratio (HSMR) analyses into the public domain on a quarterly basis. The Data Team provides quarterly reports of Hospital Mortality figures. Where these figures are perceived to be unusually high for any Hospital Site, the Data team then initiates a more in depth case note review. The case note review uses the ‘A Matter of Life and Death’ 3x2 matrix tool (NHS Modernising Agency). For patients identified as being admitted into a ward for treatment, the Global Trigger Tool (GTT) is then applied to the patient journey. A report is prepared and shared with the clinical team to generate themes for improvement.

### Quality Measurement Project

A Clinical Quality Measurement Project was commissioned in 2018, which aimed to;

1. Develop, implement and evaluate board level outcome focused data for corporate and public assurance.
2. Develop, implement and evaluate sector/directorate/HSCP level outcome focused data for improvement and assurance

3. Support greater access to data for clinical teams, so information is practically applied in support of quality improvement and assurance. (Aim three is currently not active.)

Learning from the project highlighted dashboard development and an MDT approach as key areas for consideration. In relation to dashboard development the project highlighted the drawbacks of presenting data alone, as this often raises a suite of questions that cannot be answered, and generates actions that may not be appropriate, adequate or required.

With this in mind, aims should focus on identifying information relevant to clinical services, Creating a measurement plan that outlines the data, its source, reviewer(s) and actions/comments , Ensuring that clinical services have access to the data, building a process of data interpretation, and visualising the data at Clinical Governance Forums. The project has also outlined the importance of a multi-disciplinary approach for all indicators, rather than sharing data with an individual clinician.

DRAFT

## 6: Person-Centred Health and Care Programme

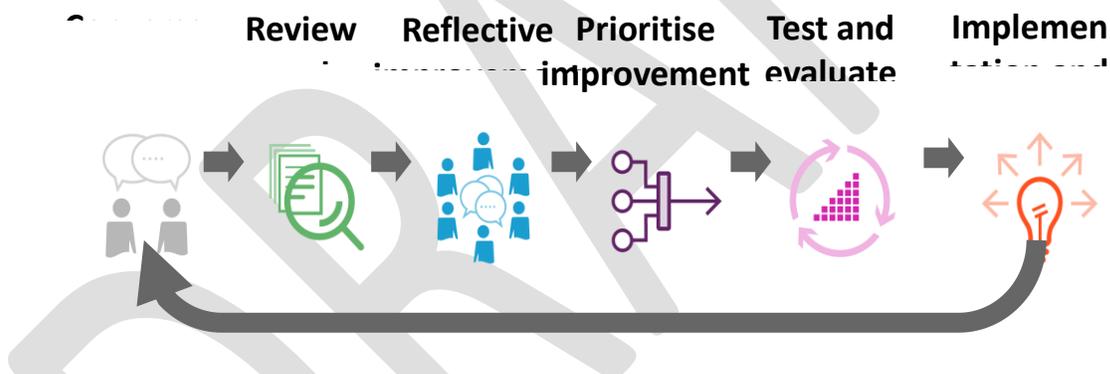
“If quality is to be at the heart of everything we do, it must be understood from the perspective of patients.”<sup>1</sup>

**6.1** The main remit of the Person-Centred Health and Care Team (PCHC Team) is to gather care experience feedback in ‘real-time’ from people receiving care or support close to or during their episode of care for the purposes of reflection, learning, improvement and whenever possible early resolution of individual issues and concerns. The PCHC Team is currently providing improvement support to eighteen (18) care teams in four acute sector/directorates.

On a monthly basis, the individual clinical teams receive support to review and analyse their care experience feedback and identify areas of excellence to celebrate within the team as well as prioritise the opportunities for improvement. Thereafter, coaching and mentoring support is available from the person-centred improvement coordinators, to help care team staff to take forward improvement actions and interventions. This is referred to as the Care Experience Improvement Model (figure 1).

The improvement aim is to achieve an overall positive care experience response of 95%, reliably sustained over time in all clinical teams supported by the ‘real-time’ care experience improvement model.

**Figure 1: Care Experience Improvement Model**

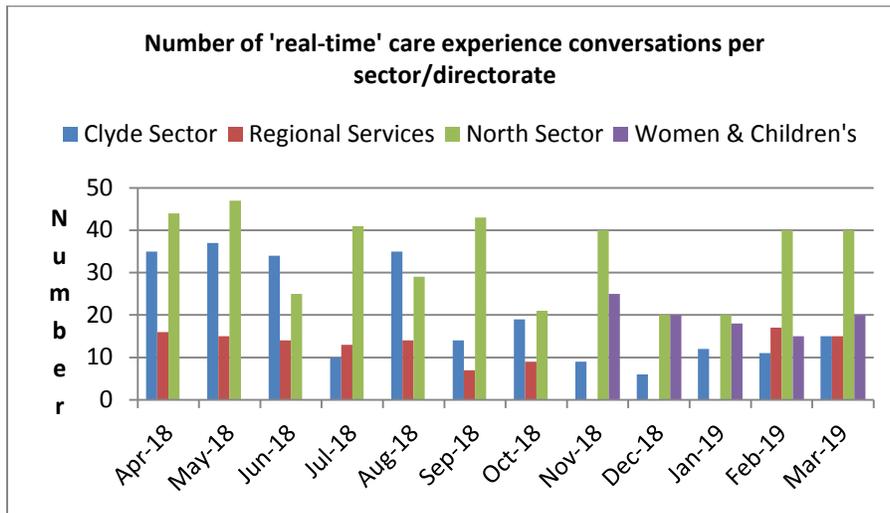


## 6.2 Quantitative summary of care experience feedback

### Number of conversations

The aim of the Clinical Improvement Coordinators is to achieve a minimum of five conversations per month in each care team. From April 2018 – March 2019 there have been eight hundred and sixty-five (865) ‘real-time’ care experience conversations across the four sector/directorates (figure 2).

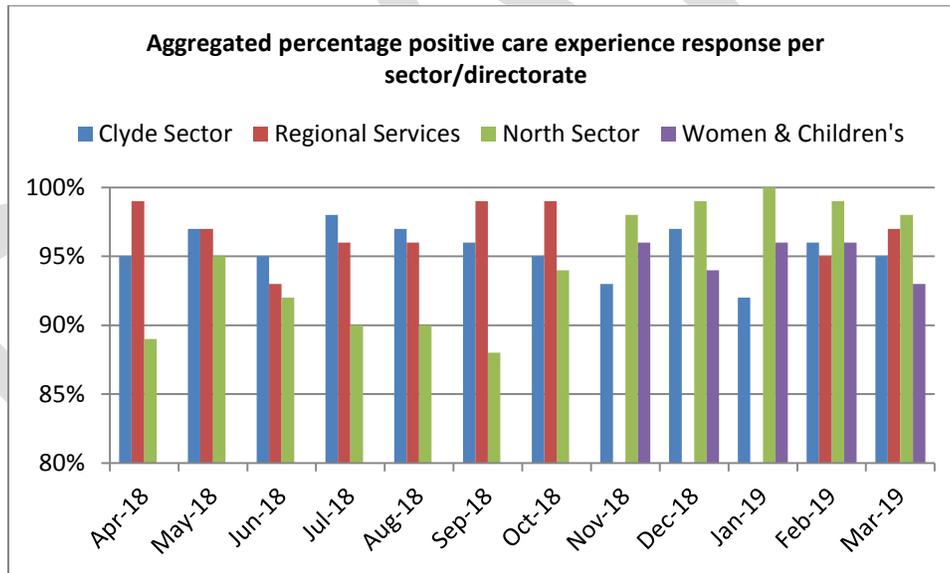
**Figure 2: Number of real-time conversations per sector/directorate**



### 6.3 Aggregated positive care experience response

The aggregated positive care experience response is a percentage of the positive responses to all enquiry questions from all conversations held each month. The aim is for care teams to achieve 95% each month. From April 2018 – March 2019 the aggregated positive care experience response across the four sectors has ranged from 91 – 97% (median = 95%) (Figure 3).

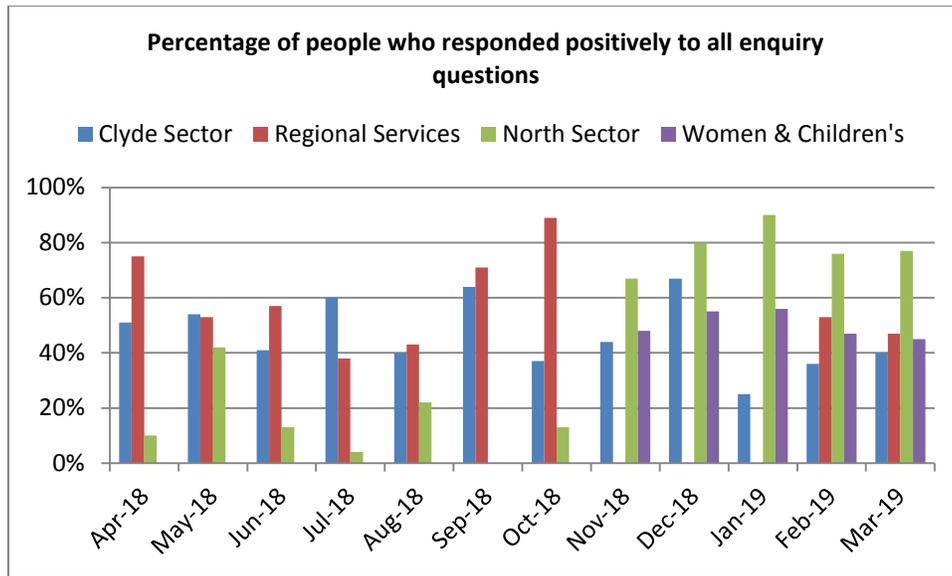
**Figure 3: Aggregated percentage positive care experience response per sector/directorate**



### 6.4 Percentage of people who responded positively to all enquiry questions

Helping care team staff to recognise the factors, which create the conditions to achieve high quality care experience, is a key feature when reviewing and analyzing the feedback. From April 2018 - March 2019 the percentage of people who responded positively to all the enquiry questions ranged from 34 – 67% (median = 48%) across the four sector/directorates (Figure 4).

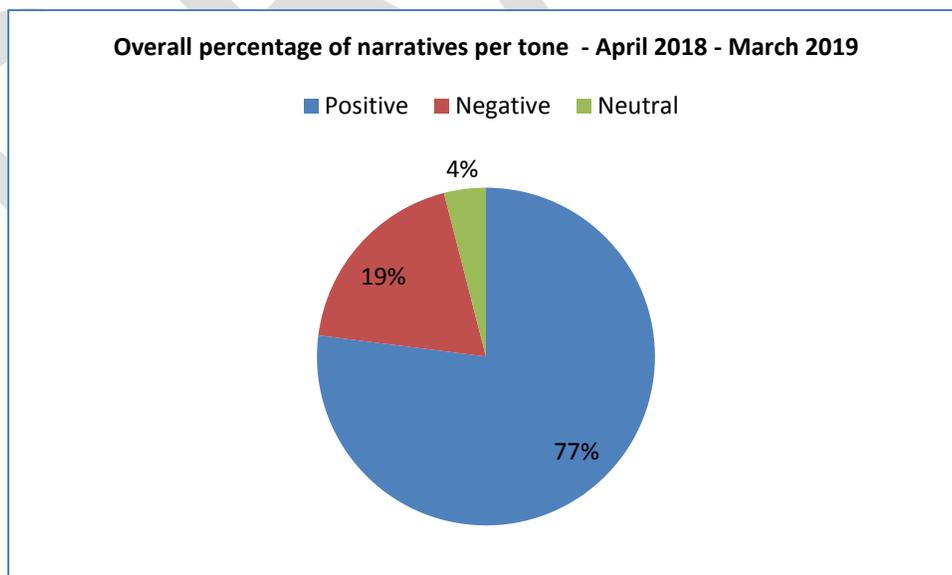
**Figure 4: Percentage of people who responded positively to all enquiry questions per sector/directorate**



**6.5 Tone of the qualitative narratives collected**

From April 2018 – March 2019 five thousand four hundred and thirty-five (5435) narratives (qualitative summaries) were collected within the four sector/directorates. From the narratives collected four thousand two hundred and four (4204 = 77%) had a positive tone, one thousand and seven (1007 = 19%) had a negative tone and two hundred and twenty-four had a neutral tone (224 = 4%) (Figure 5).

**Figure 5: Overall percentage of narratives per type (tone)**



**6.6 Qualitative summary of the care experience feedback - core themes and sub-themes**

The qualitative narrative feedback gathered in the care teams helps guide the clinical teams to direct their improvement actions and behaviors in a more targeted approach. The 'real-time' care experience

feedback is themed into a number of core domains and sub-themes. The following are some examples of the thematic analysis undertaken which exemplifies good practice and behaviour and where we need to concentrate future improvement.

<b>Theme</b>	<b>Good practice</b>	<b>Areas for Improvement</b>
<b>Communication and Involvement</b>	People feel involved and informed of their plan of care	Improved listening Ensuring people are given the opportunity to be present and/or participate in decisions
<b>Consistency and Coordination</b>	Intentional behaviours from staff to welcome and introduce themselves  Staff attention to symptom control and comfort	Not knowing their named nurse/midwife/key worker  Coordination of care within the service
<b>Environment and Facilities:</b>	Cleanliness of the environment  The experience of a calm and pleasant environment  Visiting experience	Lack of private bathroom facilities particularly in the older hospital building accommodation  The temperature of the environment -Disturbance from fellow patients and staff particularly at night  Lack of privacy in shared rooms; facilities for relatives  The absence of a TV or one that works and some  Areas not being designed appropriately to support people with a disability
<b>Mealtime Experience:</b>	Offered a choice of food and drinks to suit their individual needs and requirements	Quality of food received is variable - this can vary from the food not meeting the expectations of people to the temperature of the food and how it is presented.
<b>Respect and Dignity</b>	Attitudes and behaviours of staff  Care being provided in a respectful and dignified manner  Respect for values and preferences	Negative feedback tend to be either about single individuals or a small minority of staff
<b>Safety:</b>	The check-in frequency (care rounding) and visibility of staff is hugely positive  The safety and security that people experience from the competence and professionalism displayed by staff	Small numbers reported not having access to their call buzzer , or waiting longer than they felt appropriate to receive a response for assistance

## 6.7: Evaluation Feedback from Staff

Improvement support is provided to each care team for an average of 12 months. This approach is designed to help build improvement capacity and capability within the team, to enable the care team to use care experience feedback proactively to influence and drive improvement, and to support the leadership structure with the spread of improvements, which could be replicated over similar areas of practice. The following are some examples of feedback from care team staff on completion of the 12-month support period:

*'I've valued most getting the real-time patient feedback at the right time when they're in the unit as it makes it so much more interesting and accurate around their care. You really feel you know what the patient is thinking at the most vulnerable time of their assessment. Receiving the Monthly Reports I loved the themes; from the waiting area right through to communication covering all aspects of their care giving an overview of all things in detail. The biggest thing I value is the results of the tests of change based on the feedback, which has been rewarding and valuable to ensure the next changes are more beneficial. A big section of staff have been involved in the meetings from clerical to clinical support staff to all grades of staff, despite the Medical Team not getting involved in meetings, they have been involved in the feedback discussing the comments at our team meeting.'* (SCN, North Sector)

*'Probably thing I have valued the most is the patient feedback. If the feedback wasn't good, it allowed me to turn something that was potentially negative into a positive and ultimately preventing a complaint. Initially there was some apprehension from staff, but there was lots of good feedback and when staff realised feedback was mostly good this was good for staff morale. Feedback was good for the whole MDT including Physiotherapists and Doctors.'* (SCN, Clyde Sector)

*'I feel it has been good having someone independent coming into the ward and obtaining feedback from patients. I feel that by being independent, then this feedback hasn't been subjective and I feel that patients giving the feedback haven't felt intimidated, as I think they would feel this way if it were a member of the ward team obtaining this feedback. I feel with an independent person obtaining feedback, patients can be honest and realistic with their facts and won't feel that by saying something negative that it will impinge on their care in the ward.'* (SCN, North Sector)

## 6.8 Key learning

Analysis of the narrative (qualitative) feedback identifies that similar themes emerge from the care experience feedback within the clinical teams across the sector/directorates. In many instances the feedback identifies that improvement needs to be concentrated on developing and sustaining the reliability and consistency of existing systems, processes and behaviours of working, rather than generating completely new ideas.

There has been a noticeable improvement in the positive care experience feedback gathered from November 2019 onwards. Although it is not possible to correlate this with the increase in nursing staff numbers from the newly qualified nurse recruited to vacant nursing positions in October, it is of interest that many of the care teams have commented that this has had a positive impact.

Improvements in clinical practice and quality of care experience is found to be most prevalent within the clinical teams where a core group of staff are selected to champion person-centred actions, behaviors and interventions and where time is made available for monthly meetings to occur on a regular basis to review and analyse the feedback.

## 7: Care Assurance

### 7A: Falls

**7A:1** Falls prevention and management in NHSGGC, aligns with the Scottish Patient Safety Programme driver diagram, with drivers focused on, risk identification, prevention and management, and promoting an improvement model.

The Board have been under HSE monitoring following receipt of a contravention in April 2017. This has informed a directive approach to falls improvement to meet the required actions defined by the HSE.

**7A:2** A short life working group was established, lead by the Dir of AHPs, with the Head of Health and Safety, and Acute Falls Lead, to address the above actions indicated by the HSE, and distil the stipulated requirements into the following work plan

- The roll out of new Falls Bundles across NHSGGC, with subsequent auditing of staff learning and competency in their use.
- Analysis of equipment availability will be undertaken to inform gaps in provision.
- Falls Learnpro modules will be essential job related training for all nursing, medical and AHP staff, which include robust mechanisms for analysing staff completion developed. Further education, including that on equipment use, will be facilitated via the Falls Policy, Guidelines and Link Nurse system.
- Analysis of communication issues between departments relating to falls risk will be undertaken and identified issues addressed.
- Falls incident reporting and investigation will continue using the Datix system with progression towards a Dashboard system. Mechanisms to improve the accuracy of severity scoring of falls with harm and the investigation of SCI have been agreed.

**7A:3** Quarterly reporting on progress was provided via the Falls Strategy Group, and also through the Acute Clinical Governance Committee.

**7A:4:** Progress to date on the delivery of the actions to ensure the board aligns the falls prevention and management within the SPSP and meet the HSE actions are detailed below;

- **Policy and Guidelines**
  - Development and implementation of Board Falls Policy on Prevention and Management of Falls and the Falls Clinical Guidelines are available on Staffnet. ([Link](#))
- **Falls Bundles Implementation**
  - The falls safety bundles, a methodology advised by the Scottish Patient Safety Programme – (SPSP) have been implemented in all the inpatient acute and mental health wards across NHSGGC.
  - These falls bundles are now audited on a bi annual basis to ensure compliance and sustainability. This audit shows an overall score of 89% compliance across all components of the bundles, with actions to support further impact to address the interventions to further prevent falls with high risk individuals.
  - Falls Bundle training has been initiated for all link nurses, practice development nurses and AHPs across acute and mental health wards. This has also been included in the induction programme for all new nursing staff, and also with bank staff (appendix SBAR falls bundle implementation). Link nurses/AHPs (265) have been established in accordance with EICCAS recommendations, in all wards, and this is audited quarterly.
  - A Learnpro suite of modules has been developed, which provides 6 modules to cover a competency based training for all staff (nursing, AHPs, medical staff), to address falls risk, falls prevention, falls interventions, completion of the bundles, and completion of the medical review. These modules are defined as role essential training, for these professional groups. We have also completed a bed rail risk assessment, and intervention guidance learnpro module, which is also now live and deemed role essential training for the same staffing group, as per the falls

leanpro module.

- Both training (link person awareness of falls bundles) are in place to support learning and awareness of falls risk mitigation. This is continuous training provided by the HFC to support the wards, thus enabling a key link advisor per ward to support falls bundles sustainability.
- Training for Ancillary staff has been developed and a training programme is in place with falls awareness session as part of their induction.

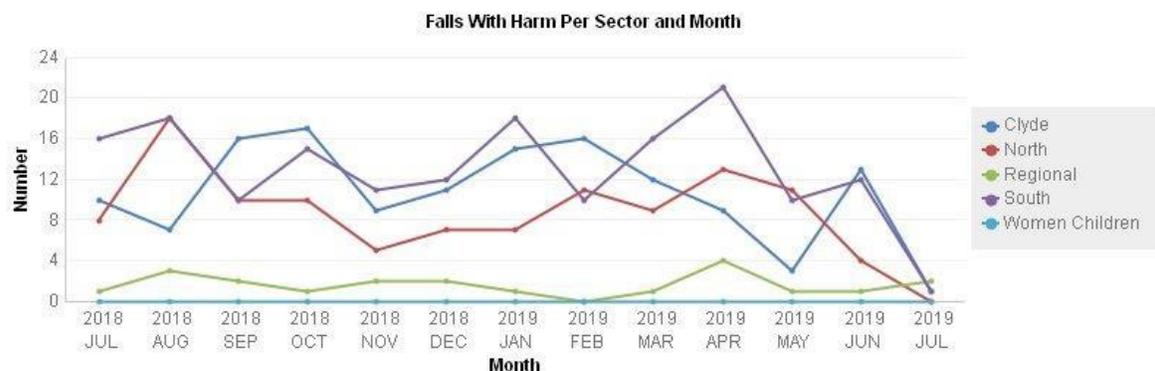
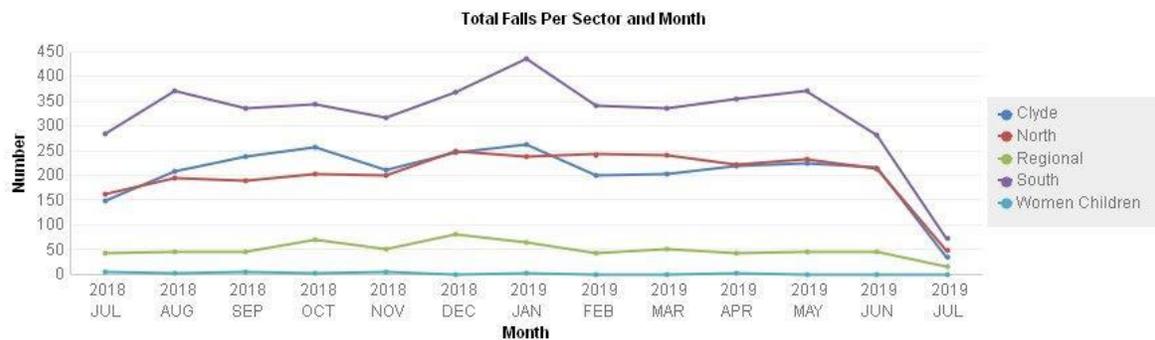
- **Communication Systems**

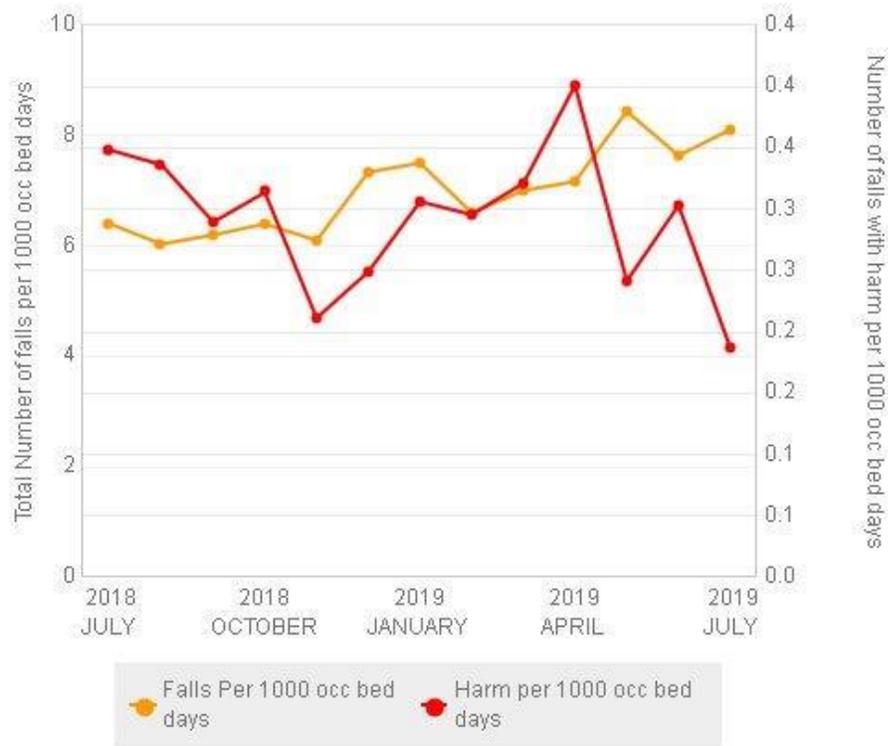
- Robust communication systems are in place between admitting services, wards, inter ward and hospital transfers.
- Analysis of the communications between identified clinical areas, has informed the development of an electronic SBAR providing information specific detail for patients with a falls risks.

- **Data Dashboard**

- The EIC CAIR dashboard is now operational, which provides live locally owned data at ward level. This provides number of falls, harms and performance of falls per 1000 bed days across the acute sector and mental health. This data provides visibility at local ward and sector level of number of falls, high risk areas (defined as more than 3 falls in one week, or one 4/5 harm), to inform targeted improvement work, and more defined reporting through local governance reporting.

The graphs below provide acute and mental health wide report of number of falls (averages 720 per month, with average of 38 falls with harm per month), and 1000 bed day rate.





High risk areas are identified below, with each sector identifying an improvement plan working with their HFC. This data has indicated that the wards with the highest falls and falls with harm activity in NHSGGC are wards in Emergency Care Medical Services (ECMS) & Older Peoples (OP) table

Data for previous 365 days Speciality 1 <sup>st</sup> May 2018 30 <sup>th</sup> April 2019	Number of Falls	Number of falls with 4/5 Harms
ECMS	3047	73
Older People & Stroke	3319	94
General Surgery	809	15
Orthopaedics	540	19
Oncology	173	1
Regional	543	7
W&C	30	1
<b>TOTAL</b>	<b>8461</b>	<b>210</b>

#### 7A:5 System - monitor and review

- To improve accuracy of reporting of harms, guidance of severity reporting has been added to the Datix system, using the national harm matrix for recording.
- To improve the review of harms (4/5 severity), within a 'no blame approach', the method used within Tissue Viability has been implemented. The hospital falls coordinators monitor all 4/5 falls severity scored incidents with the SCN and local clinical team within 2 days of the incident. An action plan is developed from the learning of this review and is shared with the Chief Nurses/AHP per sector. Themed learning is taken through the sector governance structures.

## **7A:6 Improvement Approach**

- Improvement plans are in place in each sector and focused on the high risk areas, supported by the HFC and reported through quarterly meetings with the chief nurse/AHP.
- Each sector now adopts 'Falls Friday' to raise awareness at the morning huddle of falls/ falls with harms high risk areas across the wards.
- Each sector has defined their high risk areas, within an agreed definition, and action plan.
- Safety intervention boards, to highlight to staff patients at risk, and interventions.
- Testing of falls coordinators within dementia wards to support patients need to be mobile.

## **7B: Pressure Ulcers**

**7B:1** The aim of the pressure ulcer work stream is to provide a joint seamless service by both Tissue Viability and Podiatry, in the prevention and management of pressure damage to support wards achieving 300 days with no hospital acquired pressure damage

### **7B:2 Key areas of progress**

- Pressure Ulcer Prevention and Management Policy Updated to reflect changes in joint service provision
- Datix reporting updated to improve accuracy - the new Pressure Ulcer and Management Policy stipulates that a Datix should only be completed for hospital acquired pressure damage and in partnership with either a Podiatrist or Tissue viability Nurse.
- Datix fields amended to ensure a streamlined approach from both services.
- A foot protection guide was developed, tested by staff for understanding and usefulness and refined. After refinement it was endorsed by Podiatry, Orthotics and Tissue Viability and rolled out Board wide. An information session was hosted by Podiatry and Tissue Viability for Senior Charge Nurses to provide an update on: The Pressure Ulcer Policy, Foot protection guidance, Datix reporting, Datix field changes,

**7B:3** NHSGGC operates a 'hotspot' alert system. A 'hot spot' is a clinical area that has had more than one incident of hospital acquired avoidable damage in one month or a single event in two consecutive months. If a ward is identified as a hot spot then they are offered support to address any system issues they have, in addition to this the Chief Nurse will meet with SCN to reflect on the individual cases and identify any learning and action points.

**7B:4** In December 2018 a care quality indicator dashboard went live. The dashboard can be viewed from board-wide/hospital site down to individual ward view. The hospital acquired pressure ulcer grade 2≥ data is displayed by grade, avoidable or unavoidable and incidence per 1,000 bed days, 300days pressure ulcer free and hotspots. The data is refreshed on a daily basis and can be viewed as a run chart, RAG monthly table (RAG= red avoidable harm, amber unavoidable harm and green no harm), quarterly and six monthly view. This allows ward staff to view patient harm as live data and use it as a focus for their safety briefs at shift handover. The dashboard allows the ward staff to own their data and utilise it in relation to improving the quality of patient care. The dashboard is a major advancement; however it relies on accurate input of information.

## **7C: Care Assurance in Mental Health inpatient services (AIMs)**

**7C1:** After testing a mental health version of the CAS and comparing it with other tools, Mental Health Inpatient areas across all bed holding HSCP's have adopted the Accreditation of Inpatient Mental Health Services (AIMS) approach, to add to the suite of care assurance mechanisms used. AIMS is a multidisciplinary set of standards hosted by the Royal College of Psychiatrists College Centre for Quality Improvement.

**7C2:** The standards are based upon evidence based practice, practice based evidence and expert consensus including a strong model of co-production with carers and experts by experience. The standards follow

the pathway of the patients journey from admission to discharge and examine 5 themes – Timely and purposeful admission, Safety, environment/facilities, therapies/activities and policies, protocols and staffing related issues. Standards are updated on a three yearly cycle and are divided into 3 types of standards; Type 1 standards are considered essential to good mental health care, including fundamentals of care, rights, dignity, safety etc and wards are expected to achieve 100% of these standards. Type 2 standards are considered good practice and at least 80% of these must be met. Type 3 standards are desirable or standards that are not the direct responsibility of the service and at least 60% of these must be met.

**7C:3** The approach builds on and showcases the work already undertaken across NHSGGC, and allows the multidisciplinary teams in wards to self-review against this comprehensive set of Mental Health and specialty specific standards. An external peer review team visit the ward to undertake an assurance visit. The external team consists of a doctor, nurse and service user or carer (with experience of the specific environment they are visiting) as a minimum. A draft report is then produced and sent to the ward for comment and once this process is complete the report goes before an accreditation committee, co-chaired by a nurse and a doctor and a decision on accreditation, deferral or non-accreditation is made. Teams engaged across cycles demonstrate an increasing number of standards achieved on each occasion which indicates ongoing quality improvement across the approach. We have a planned programme for undertaking AIMS across inpatient sites and specialities which commenced in 2018 and will progress in a planned way throughout 2019 - 20.

#### **7D: Excellence In Care/ Care Assurance Standards**

**7D:1** There is a dedicated lead for the Excellence Care programme in NHSGGC, along with two support nurses one for acute (secondment finishes July 2019) and one for partnerships (secondment until November 2019).

**7D:2** Key areas of progress have been:

- Falls and pressure ulcers per 1,000 bed day indicators submitted to the test environment within NSS to date.
- The board will start reporting on NEWS, PEWS/PEWS escalation compliance from early July 2019 and it is anticipated the partially/totally upheld nursing/midwifery complaints will be ready for submission within this time scale.
- Work is ongoing to provide the workforce indicator data with the workforce team and e-health.

#### **7D:3 CAIR (dashboard)**

The CAIR dashboard is available across adult in-patients, paediatrics and mental health for falls and pressure ulcers outcomes indicators. It has been agreed by the chief nurses/board nurse director that there is no longer a requirement to collect process measures for these indicators. The following process measures will go live in middle of June: hand hygiene, NEWS, PEWS/PEWS escalation and SICPs (noting NEWS & PEWS are EiC indicators).

The complaints indicator will be currently in development with complaints team, Datix and e-health. Corporate Practice development have completed a walk round the acute sites to ensure all SCN are able to access CAIR and a briefing has been written to support staff with mental health.

#### **7D:4 CAS standards**

CAS Standards for adult acute, maternity, medicines and paediatrics are all still at draft stage, and will be published on the website when available.

#### **7D:5 CCAAT (combined care assurance audit tool)**

Development of the PCCAAT, NCCAAT is underway, and reflects the format of the adult tool. The Board is also looking at the development of a theatre version of the assurance tool.

## 8: Conclusion

8.1 As described in the introductory section this report can only provide insight into a small sample of the overall clinical governance related activity within NHSGGC.

From the information provided we have demonstrated the significant commitment of the Board to managing and improving the quality of care we provide, and that the clinical governance structure is well developed.

8.2 There remains an ongoing focus in continuously developing processes and systems to ensure robust recognition of issues, and in taking forward any necessary improvement.

## 9: Key Objectives for 2019 – 2020

9.1 The aims for the forthcoming year will be developed in the framework of the NHS GG&C Healthcare Governance Strategy. Some of the key objectives are as follows:

### Person Centred Care Objectives

- Implement person centred visiting, exemplifying caring relationships, in all ward areas by March 2020.
- More extensive implementation of person centred care planning, which will enhance the way we are embedding “what matters to me”, by March 2020.

### Effective Care Objectives

- Clinical Quality Indicators project will be further developed to regularly provide a set of measures that support corporate oversight of healthcare quality at the Board Clinical Governance Forum.
- Develop specific clinical informatics objectives for key clinical pathways to include the use outcome critical measures, to resolve variation and to enhance the quality of care in key condition specific care groups, including cardiac services and thrombosis
- Enhance the access to and sharing of information from existing data stores e.g. Discovery, and work with the Realistic Medicine lead to apply the Scottish Atlas of Variation in improving the quality of care.

### Safe care objectives

- Review and redevelop the quality improvement programmes focussed on reducing the incidence and consequences of avoidable deterioration.
- Maintain the process of managing and reviewing significant clinical incidents, ensuring compliance with best practice and HIS national guidance framework
- Evaluate the experience of patients and families who are engaged in the review of significant clinical incidents