Clinical Governance Annual Report

2019-2020

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.

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.

1a: Stage 4 Escalation

On 22 November 2019, NHS Greater Glasgow and Clyde (NHS GGC) was escalated to Stage 4 of the NHS National Performance Framework in light of ongoing issues around the systems, processes and governance in relation to infection prevention, management and control at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC) and the associated communication and public engagement issues. On 24th January 2020, NHS Greater Glasgow & Clyde was also escalated to Level 4 in respect of Scottish Government concerns regarding further performance issues across a number of key areas including performance on scheduled and unscheduled care and challenges with the primary care out of hours service. Stage 4 is defined as 'significant risks to delivery, quality, financial performance or safety; senior level external transformational support required.' Escalation to Level 4 requires the Scottish Government to have direct oversight. An Oversight Board was established in December 2019 to address the QEUH/RHC issues, chaired by Professor Fiona McQueen, Chief Nursing Officer and reporting to the Chief Executive Officer of NHS Scotland.

An Infection Prevention and Control and Governance (IPCG) Subgroup was established in December 2019 to support the Oversight Board by focusing on issues relating to infection prevention and control and associated governance that gave rise to escalation to Stage 4. It is currently chaired by Diane Murray, the Deputy Chief Nursing Officer. In addition a communications and facilities sub group was also formed.

Reports from the above are still outstanding but action plans to put in place will be developed and monitored by the relevant governance groups.

1a.1: Queen Elizabeth University Hospital External Review Report

The decision to establish the Review had been prompted by public and political concern following reports of the deaths of three patients between December 2018 and February 2019.

The remit of the review was to establish whether the design, build, commissioning and maintenance of the Queen Elizabeth University Hospital and Royal Hospital for Children has had an adverse impact on the risk of Healthcare Associated Infection and whether there is wider learning for NHSScotland.

The report was published on the 15 June 2020. The Chief Operating Officer for NHSGGC is overseeing the implementation of the recommendations from this report. Progress on this will be reviewed by the relevant governance committees.

1a.2: Public Enquiry QEUH Glasgow and RHCYP Edinburgh

The inquiry commenced on the 3 August 2020 and is being chaired by Lord Brodie QC. It will examine issues at the Queen Elizabeth University Hospital (QEUH) in Glasgow, and the Royal Hospital for Children and Young People (RHCYP) and Department of Clinical Neurosciences in Edinburgh.

1b: NHSGGC GP Out of Hours

The NHSGGC GP Out of Hours service was placed into business continuity arrangements in February 2020. This was in response to a number of significant issues facing the sustainability of the service. In addition, the situation with the GP OOH service was also part of the escalation process from Scottish Government.

As part of business continuity arrangements the service has reduced to running from a smaller number of Primary Care Emergency Centres across the Health Board; Stobhill, Victoria, RAH and overnight provision at the Vale of Leven which has historically been provided by the Integrated Care arrangements at that site. Work has been progressing around service redesign in order to support the staff working in the service to provide appropriate care to patients.

"Walk in" attendances have been stopped, in part due to the response to COVID 19. From June 2020 an appointment system has been launched throughout the service. Patients are now expected to phone NHS24 and those requiring further assessment are passed to the GP OOH service. We have moved to carrying out telephone consultations and only bringing patients into sites or for house visits where this is necessary. In addition the service has launched "Near Me" video consultations to support patient assessment.

Work has been carried out to improve environmental conditions for staff, to increase the workforce including salaried clinicians and to stabilise and equalise GP pay.

Further work is ongoing to consider the feasibility of re-establishing a GP OOH service presence in Inverclyde and the Vale of Leven areas.

Work is progressing of developing appropriate performance metrics and both risks and issues registers.

2: Key achievements and examples of improvements

2a: Key Achievements

Key achievements in 2019-20 are:

- A number of thematic reports have led to significant systems improvement, two examples are Clozapine safety and adoption of a "stop before you block" system in cases performed under local anaesthetic (as mentioned in the body of the report).
- Ongoing support to key safety programme 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
- From 1 April 2019 – 31 March 2020 **eight hundred and forty-one (841)** real-time care experience feedback conversations were held across five acute sector/directorates.
- The **overall aggregated care experience response** ranged from **96 - 100% (median = 98%)**.
- Six thousand and forty-two (6042) narratives (qualitative summaries) have been collected. **90%** (n =

5429) had a positive tone, **8%** (n = 457) had a negative tone and **2%** (n = 156) had a neutral tone (Graphs 4,5).

2b: Examples of Improvements

The Quality Improvement Team continue to support teams across NHSGGC with local quality improvement projects. This section's highlights a selection of projects where there were improvements to care.

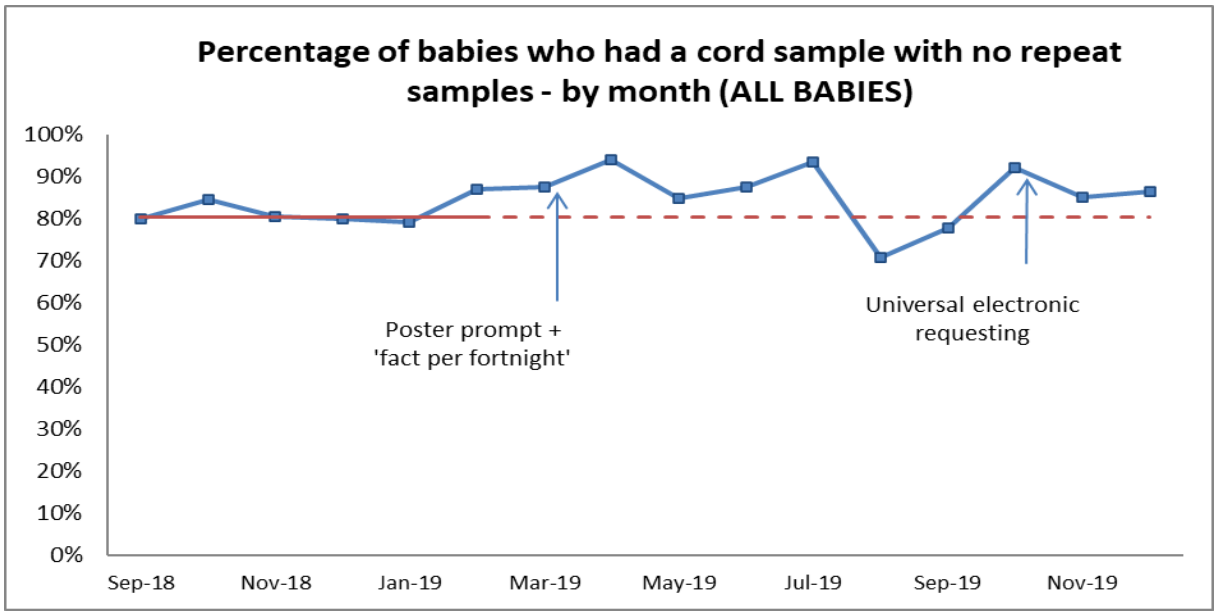
2b.1: Getting Cord Bloods Right

Obstetrics and Gynaecology

National guidance states babies born to rhesus negative women require a cord blood sample to determine the baby's ABO and Rh group. This is a pain-free and non-invasive method to establish baby's blood group. In QEUH recurring requirement of capillary sampling for baby's rhesus status was noted. When this happens it means taking a sample from the baby, which is uncomfortable for the baby and mother, has additional costs and can sometimes delay care.

To quantify this baseline data was collected over 5 months which showed on average the need to take a further sample occurring for 18.9% of babies. A variety of causative factors were identified, including missed samples, insufficient sample (including haemolysed/clotted samples which could not be analysed) and sample label errors.

A multidisciplinary group comprising Midwifery, Neonatology and the Transfusion service was established. This collaborative approach enabled process mapping of the blood sample journey and development of interventions to increase the success rate.



The two changes to practice are described below

1. Using Posters to prompt action and Fact of the Fortnight to highlight the improvement need
This 2-part intervention for labour ward staff aimed to minimise number of missed samples. This intervention has had the desired effect and there missed cord samples reduced from 11% to 6.5%.

2. Universal electronic requesting (1st October 2019)
Despite all other transfusion requests being electronic, cord bloods were paper request forms. Data collection identified missed reports as a consistent issue. In October 2019 labour ward universally introduced electronic requesting of cord bloods. This aimed to reduce variability and errors from handwritten forms and missing reports.

Total improvement by December 2019: baby's having accurate cord blood sample with no need for repeat has risen from 80% to 86.4%. This project is ongoing with further improvement observed but still to be

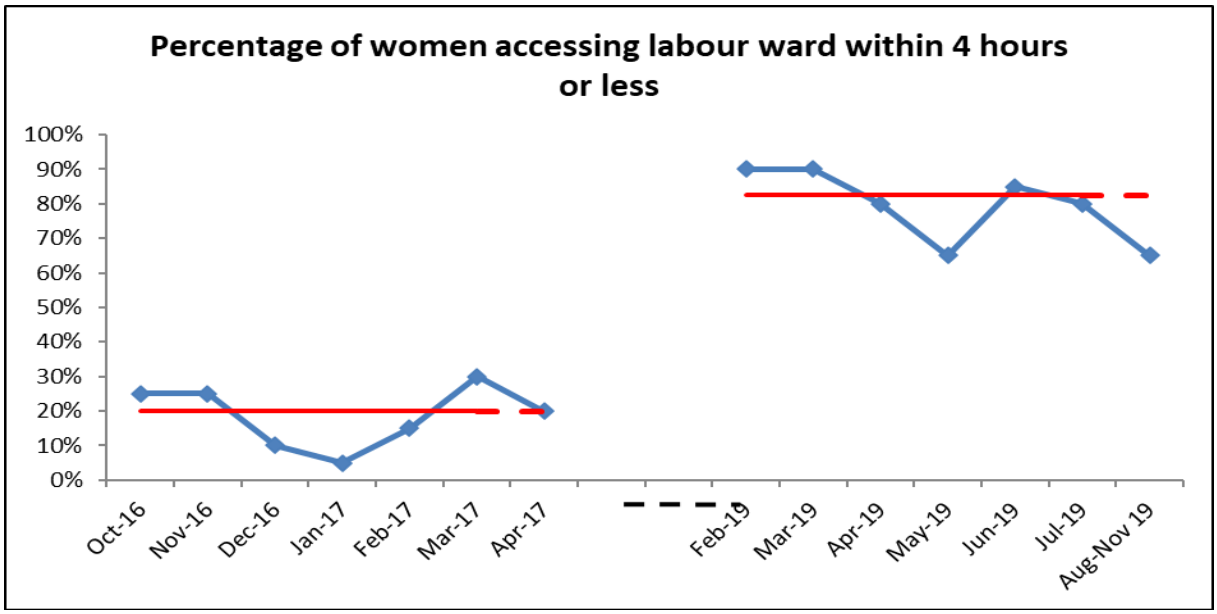
reported.

2b.2: Induction of Labour
Obstetrics and Gynaecology

To achieve ≥80% of all women ready for transfer to labour ward within 4 hours for women whose labour was induced in the QEUH by December 2019.

Induction of Labour (IOL) accounts for 33.9% of births in the QEUH during 2019.[1] A quality improvement project carried out in 2016/2017 showed only a median of 20% compliance of transfer within 4 hours.

The project aims to increase this to 80% by December 2019 as well as clarifying expectations of all stakeholders surrounding the induction process. Since February 2019 a total of 140 cases were clinically reviewed and 34 of these women completed a questionnaire. As a result several interventions were implemented which included moving the admission time of first time mothers to the ward, the adoption of an IOL leaflet which had been successfully introduced in another GG&C site, the introduction of a 'welcome induction pack' which was given to all women on admission and the inclusion of patient numbers waiting to go to labour ward at medical handover.



The measurement of transfer to labour ward within 4 hours of 'ready for transfer' saw an improvement when compared with the baseline data. The baseline median was 20% and rose to 83%. 97% of women agreed or strongly agreed that they had both a good understanding of the process before they started their induction and that they felt supported by the staff on the ward.

There has been the successful achievement of the 80% target in the time from ready to transfer to labour ward < 4 hours. Furthermore, the expectations of women is being addressed by the introduction of new patient literature at clinic and a 'welcome pack' on arrival at antenatal ward as a reinforcement. This has also improved staff morale and provided an effective clinician/patient communication which is paramount to the women's perception of their IOL.

2b.3: Nutritional Screening in Rehabilitation and Enablement Teams
Rehabilitation and Enablement Teams (RES) Teams across all Health and Social Care Partnerships

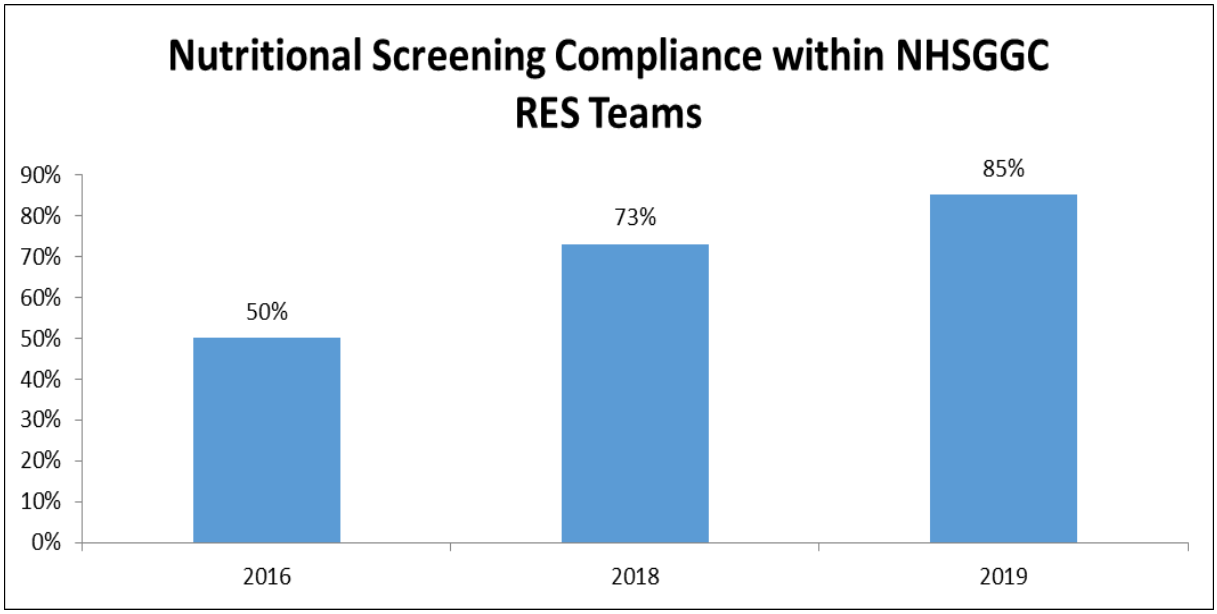
To increase nutritional screening within NHSGGC RES to 95% by the end of 2020.

NHSGGC has adopted the Malnutrition Universal Screening Tool (MUST) which is a validated tool that establishes malnutrition risk in all adult patients. Patients should be screened using MUST and a person centred care plan developed when required.
There are an estimated 3,000,000 people at risk of malnutrition at any one time within the UK. Studies suggest that up to 93% of these people are living in the community. It is essential therefore to screen patients

routinely in the community in order to identify and treat those at risk.
Previous data confirmed that the RES teams were not recording nutritional screening assessments for all patients

The RES team commenced an improvement project identifying measures to determine if the various components of the MUST screening had been completed and whether the appropriate subsequent actions had been taken e.g. referral to dietitian, dietary advice given etc.

Teams were able to review their data weekly, identify any gaps or challenges and to consider any changes which might lead to improvement. They were encouraged to formulate action plans based on this data for their respective areas.



The compliance rates have increased in 8/9 areas which participated, and this has resulted in an overall improvement to 85% by the end of 2019

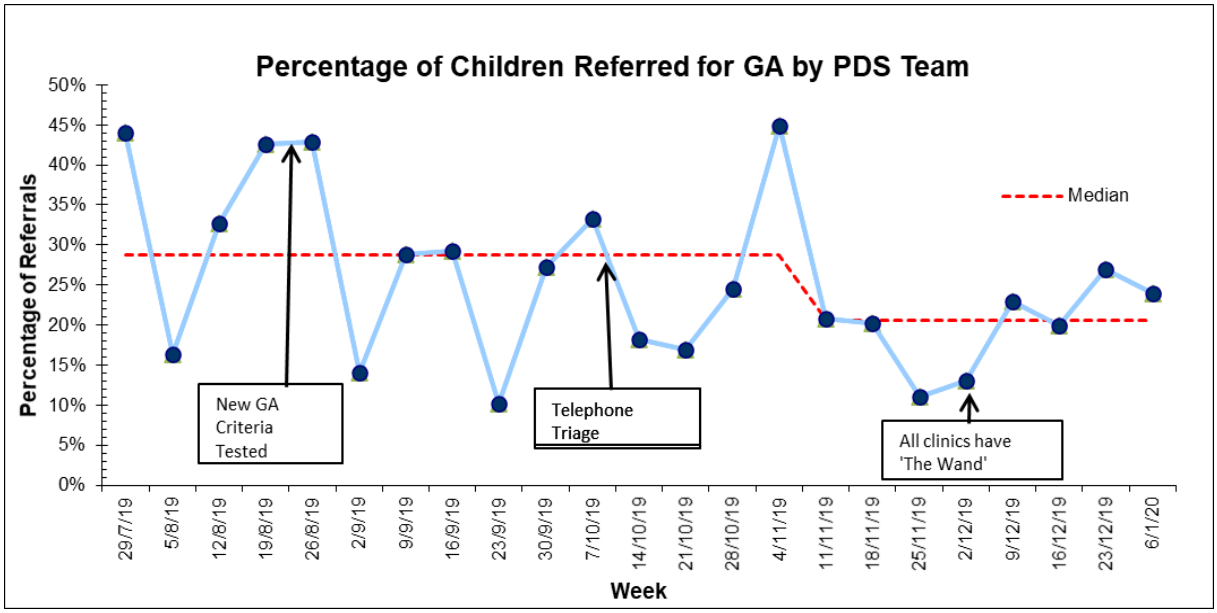
2b.4: Reducing the Number of Children Referred for Teeth Extraction using General Anaesthetics

NHSGGC Public Dental Service

In April 2019, the waiting times for children referred for teeth extraction using general anaesthetic (GA) in NHS GGC was longer than 35 weeks (breaching the Scottish Government target of 18 weeks from referral to treatment). Reasons for this include a shortage of anaesthetists at the Royal Hospital for Children as well as a reduction in theatre sessions. One solution proposed was to reduce the percentage of children receiving GA by using other treatment pathways as an alternative.

The project team identified several change ideas. The first idea (tested in August ’19) was a new referral criteria for GA for the assessing clinicians at the Public Dental Service (PDS) to ensure that all patients were referred to the most appropriate pathway, this has now been implemented.
In October 19, the team decided to test a telephone triage service. This allowed clinicians from the PDS to contact newly referred patients parents or carers to discuss the alternative treatments to general anaesthetic available (e.g. Inhalation Sedation, the Wand, Cognitive Behavioural Therapy (CBT)) and consider the waiting times and location of these options. In addition, more Wands were purchased for all PDS clinics and more staff were trained to use them. In January 2020, CBT training was provided to staff in the PDS as another method of alternative treatment.

The run chart below shows there was a shift in the percentage of referrals made for GA by the PDS from 29% to 20%. The next steps for the service are to raise awareness of the new referral pathway and the alternative treatments with the General Dental Practitioners.

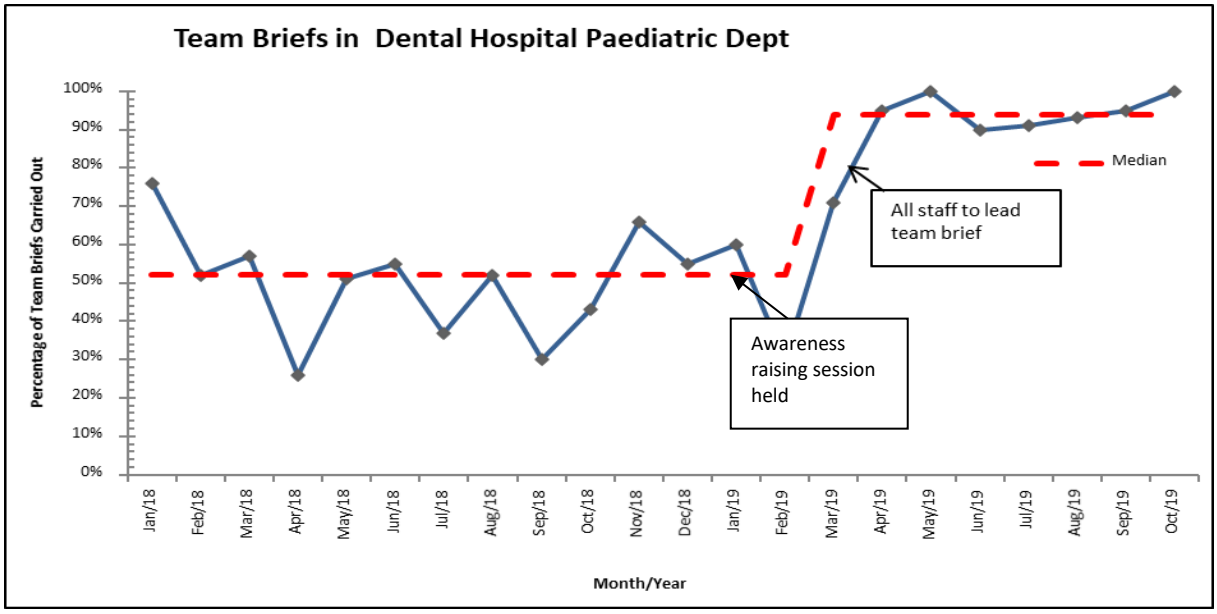


2b.5: Team Brief in the Paediatric Department at the PDS

NHSGGC Public Dental Service

The Paediatric Dentistry team wanted to introduce a team brief at the morning and afternoon daily huddle's to allow staff to identify any issues which may arise during the session (e.g. staffing, special requirements for patients) as well as to allow the staff to see who was on duty for the sessions. Unfortunately, the brief did not take place twice a day which led to confusion by the team.

An information session was held in March 2019 with the whole department present to discuss the importance of the daily briefs and to gather feedback from staff about what worked well, what didn't work and what could be improved in the sessions. It was agreed by the team to test the change that the team brief could be led by all members of the team instead of only senior staff. The chart below shows the increase in % of Team briefs taking place.

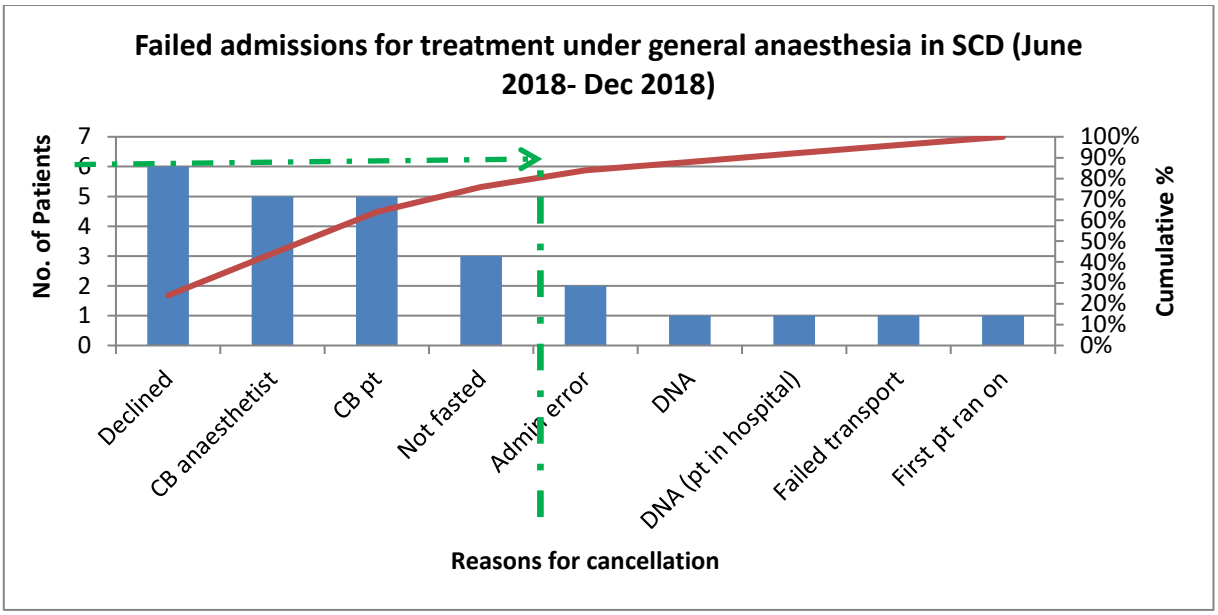


2b.6: Reducing the number of on the day cancellations for Special Care Dentistry patients requiring General Anaesthetic (GA) in the Public Dental Service

NHSGGC Public Dental Service

The waiting times for special care dental patients who require GA for treatment has risen due to a lack of anaesthetic cover. The Special Care Dentistry (SCD) team decided to look at the on the day cancellations

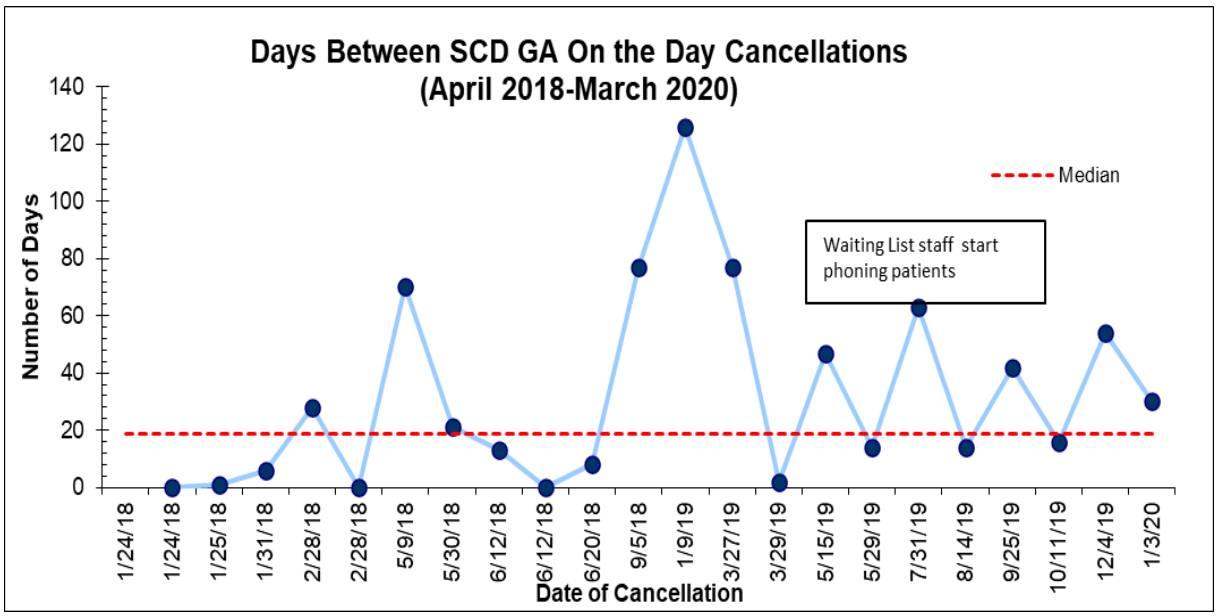
for GA as this was an area they could influence which could reduce the waiting times. From January 2017 to December 2017, 25 patients were cancelled on the day of admission. The reasons were analysed and are displayed in the Pareto chart below:



A brainstorming session was held with Public Dental Service staff and a survey sent to the anaesthetists working with special care SCD patients to get more information about the reasons why they were cancelling sessions as well as allowing people to contribute ideas for reducing the number of cancellations. Several suggestions were made and acted upon;

- Waiting list staff telephoned patients 48 hours before their appointment to check they were still able to attend and to remind them about the fasting instructions.
- A pre-op assessment was introduced for patients in September 2019 to reduce the number of cancellations by the anaesthetists who felt the patient wasn't medically fit.
- A Challenging Behaviour pathway was developed with patients being routed to the appropriate clinical setting for treatment.
- Links were established with Learning Disability nursing staff to access support for nervous patients prior to treatment.

The T Chart below shows the number of days between the on the day cancellations in the service between April 2018 and March 2020.



Although there hasn't been a shift in the median, the chart shows that the days between on the day cancellations has increased from the beginning of 2019 when the changes were tested and implemented.

2b.7: Improving Observation Practice (IOP)

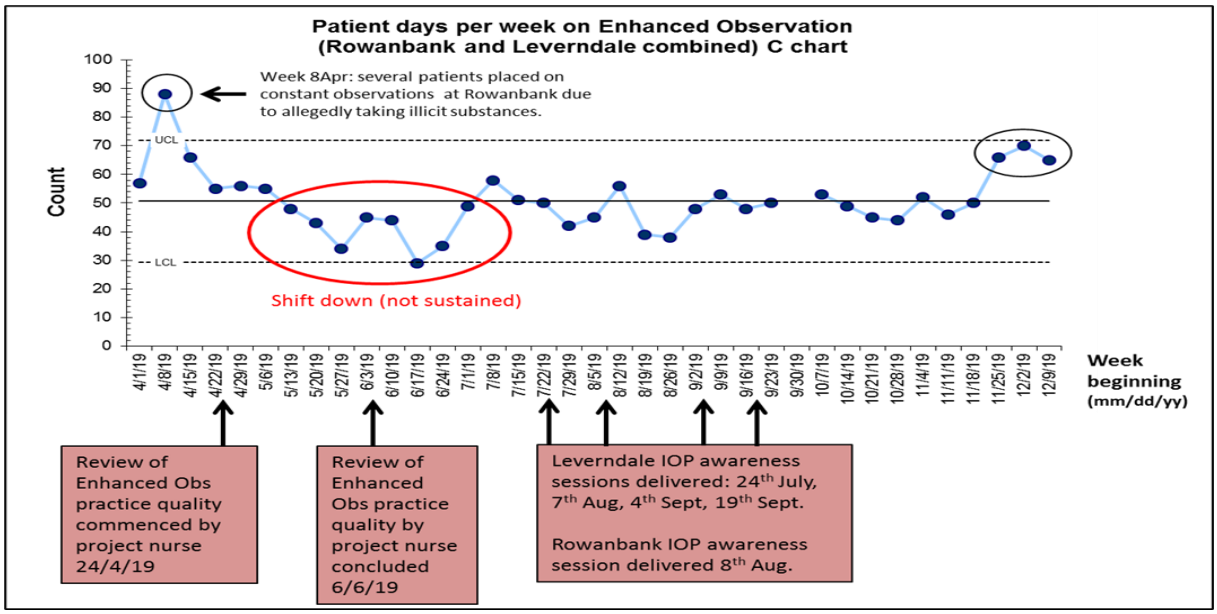
Forensic Mental Health

The Directorate of Forensic Mental Health & Learning Disabilities (DFMH&LD) set up a short-life working group to examine enhanced observation practice and to consider the implications of the new guidance produced by Healthcare Improvement Scotland (HIS) and the Scottish Government: "From Observation to Intervention". The guidance views observation practice as one small part of mental health care practice and recommends that it cannot be undertaken as a standalone task, at a distance from a patient's wider clinical needs. The new guidance is underpinned by seven key principles that reflect the ethos and philosophy of the new approach.

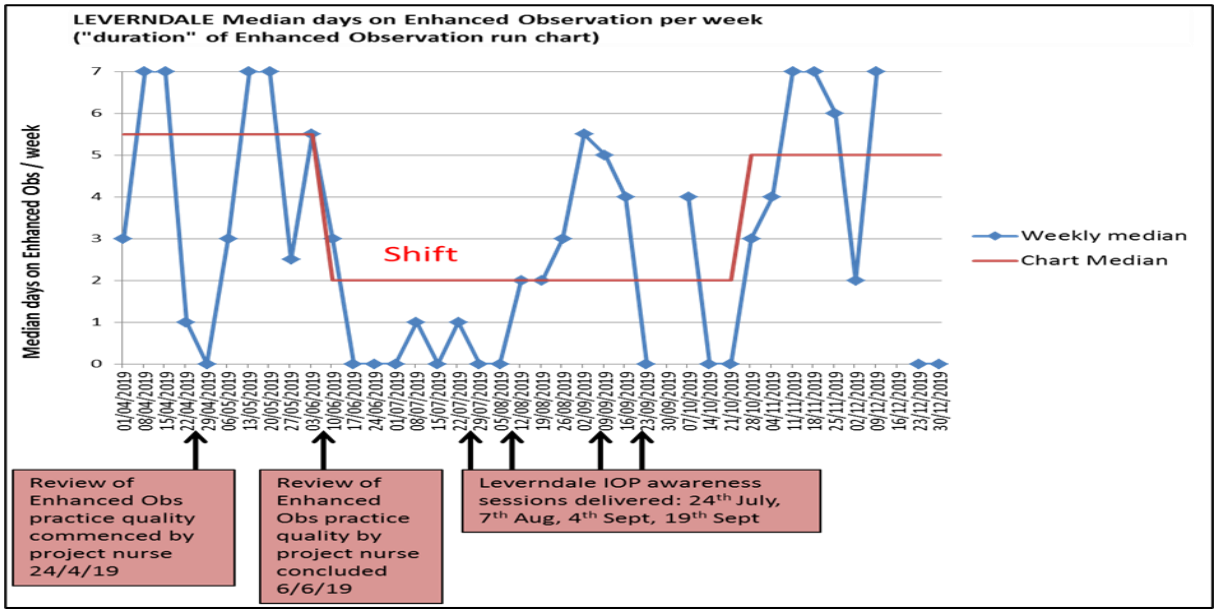
One of the resulting actions was the employment of an IOP project nurse, whose remit included:

- The rolling out of awareness sessions to all relevant staff on the new guidance 'From Observation to Intervention.'
- The development within, and spread across, test sites of national best practice on interventions for patients who required support.
- Collecting measurements related to improvements in observation practice:

The initial aim was to achieve a 10% reduction in the frequency of observations and in the duration of observations over the 6 month period April – Sept 2019.
Between May and July 2019 (8 weeks) there was a shift in the *frequency* of ward Enhanced Observations, demonstrating an improvement but this was not sustained (see chart below).



There was a shift in the median *duration* of Enhanced Observation in Leverndale wards during the period June 2019 and October 2019 (20 weeks - see chart below) However, this was not sustained



3: Clinical Governance Arrangements

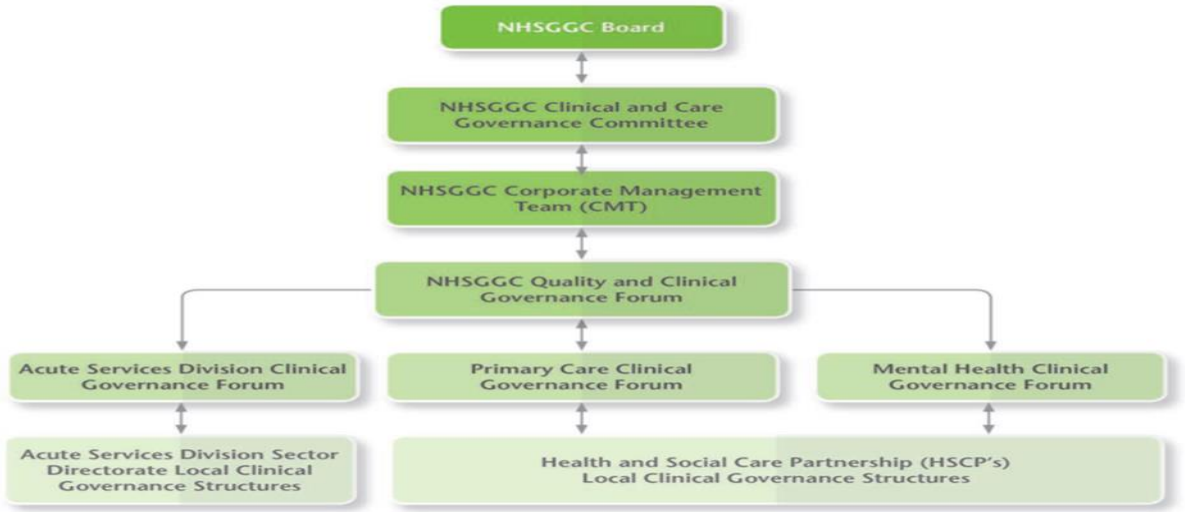
3a: Governance Arrangements

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 & 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.

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.



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.

3b: Board Clinical Governance Forum

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:

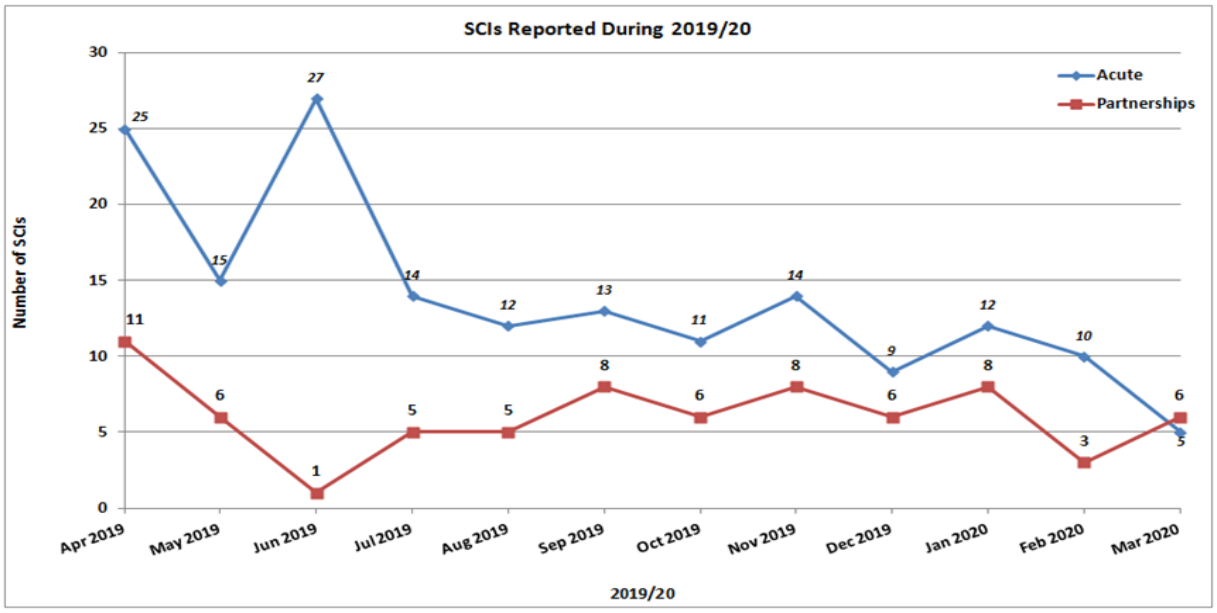
- Quarterly Clinical Risk Management Reports – Acute, Mental Health & Partnerships
- Confirming Improvement Following Serious Clinical Incidents (SCI's)
- Child Protection Update
- Adult Support & Protection Update
- Clinical Effectiveness Report
- Hospital Standardised Mortality Ratio (HSMR) Update
- 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
- 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

4: Patient Safety and Clinical Risk Management

4a: Clinical Risk Management

4a.1: Significant Clinical Incidents (SCI's)

From April 2019 until March 2020, a total of **240** clinical incidents were escalated to SCI status which is a decrease of 56 events from the previous year (Acute – 167, Partnerships – 73).



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

4a.2: Level 4/5 Process

This screening tool ensures that for those incidents 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

- Following a number of SCIs the 'Stop before you…' pause before a treatment or procedure has been extended into non theatre situations to ensure the correct patient and site / laterality is being treated.

- A bleeding fistula in a renal patient is considered an emergency however a patient had difficulty in accessing emergency services through NHS24 and an NHSGGC Emergency Department. The patient was treated 6 hours after noticing the bleeding. The renal service has adapted the algorithm for 'Complication: Bleeding AV Access' and this has been shared with the Scottish Ambulance Service, NHS24 and Emergency Departments within NHSGGC.

- Management of constipation in Learning Difficulties Guidance has been developed with associated training sessions given to all staff after an incident where there appeared to be lack of consideration of constipation as a cause of faecal incontinence. This is very common in people with specific genetic conditions.

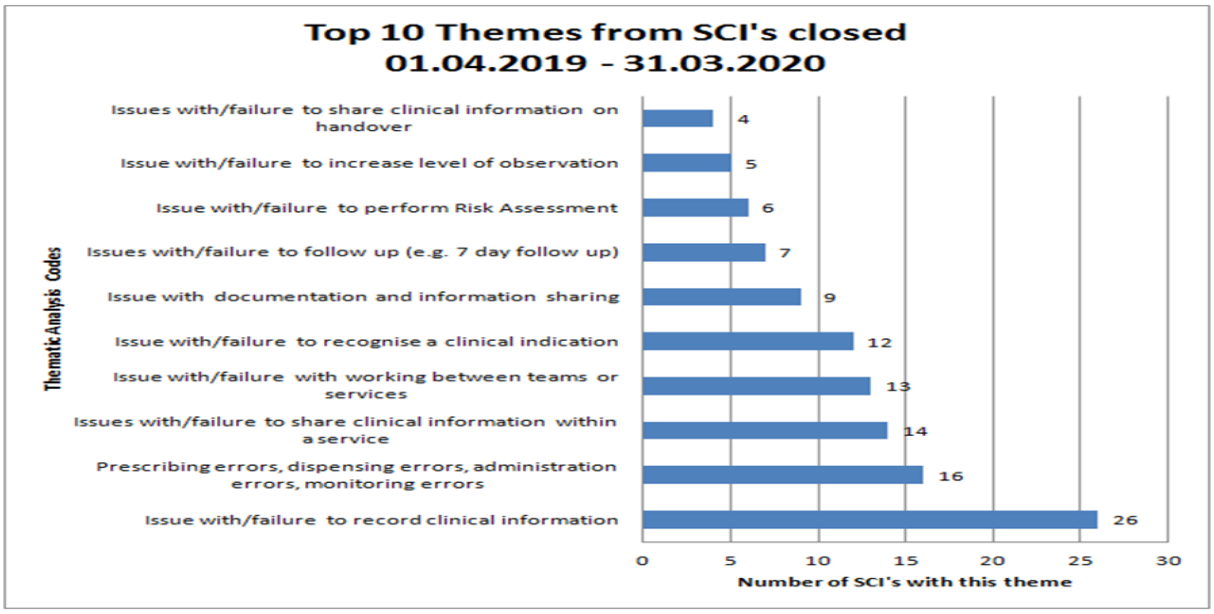
- A Significant Clinical Incident Review was undertaken following a Clozapine Red Result over the festive period. On interviewing staff it became clear that clinicians did not think the current standards allowed for the inpatient staff to upload blood results onto ZTAS and saw this as a role always undertaken by pharmacy. Child and Adult Mental Health Services (CAMHS) have since developed their own Clozapine Bundle to enable Clozapine administration to be managed within the unit. All medical staff and junior medical staff can now access clinical portal and all charge nurses will gain access. Consultants have advised that a written handover is now in place to ensure the process runs well.

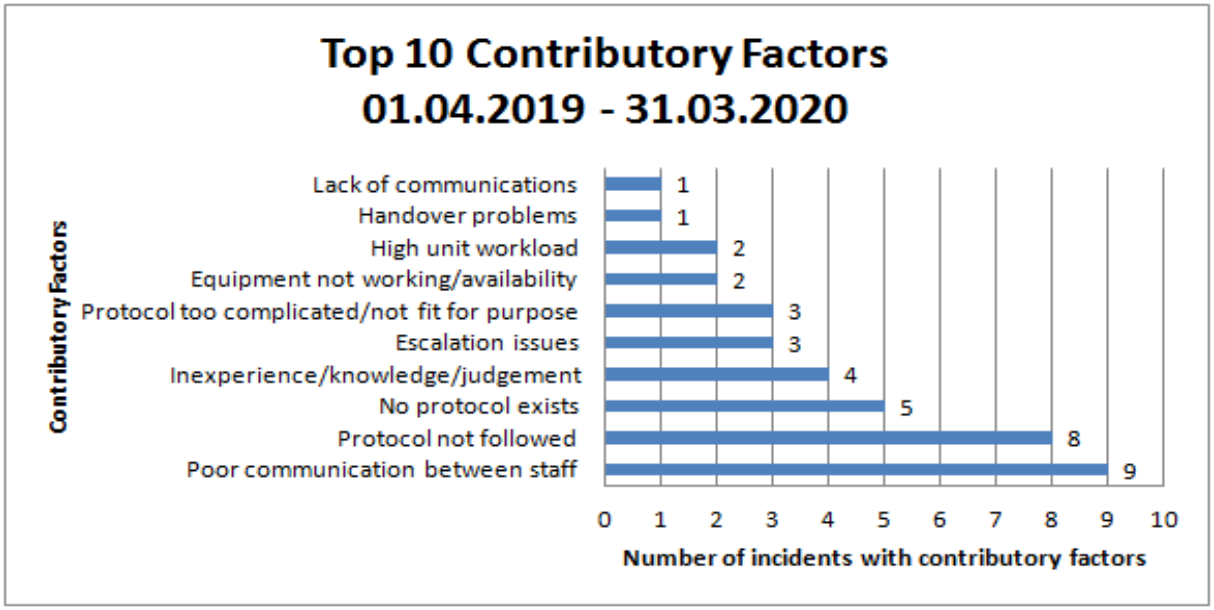
- Hypoglycaemia boxes have been introduced within Renal Units after it was identified that there has been difficulty obtaining glucose during a cardiac arrest call. Emergency Departments have also introduced this after a patient was prescribed insulin 80 units in glucose 20% when it should have been 8 units.

- A quality improvement project was undertaken between Alcohol and Drug Rehabilitation Services (ADRS) and Community Mental Health Team (CMHT) and included learning for all community MH services and ADRS including homelessness and mental health.

4a.4: Thematic Analysis & Contributory Factors

The Clinical Risk Team have been collating themes from closed SCI's across the Board, these are the top 10 from 91 closed SCI's within this time frame. Another chart has been included with the top 10 contributory factors from this timescale.





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 events are investigated as Significant Clinical Incidents (SCIs).
24 ASEM events occurred during 2019/2020. This is an increase of **4** events from the previous year.

	2018/2019	2019/2020
Death or serious harm related to the use/function of a device	1	-
Grade 3 or 4 Pressure Ulcers	-	2
Local anaesthetic performed on wrong body part	4	-
Medication error	9	13
NG Tube Misplacement	1	-
Retained item	4	2
Serious blood transfusion incident	-	1
Surgery performed on wrong body part	-	4
Surgery performed on wrong patient/ wrong surgical procedure	1	2
Total	**20**	**24**

4a.6: Training and Education for Patient Safety

In the past year, education and training has continued to be a significant component of activity within Clinical Risk. The main area of training is Root Cause Analysis (RCA) training, which is aimed at staff who have been asked, or are likely to be asked to lead a Significant Clinical Incident investigation. From 1st April 2019 to 31 March 2020, 63 staff have accessed this training.

RCA training is currently run as a half day workshop and shortly before the COVID pandemic, plans were being made to update the training, utilising e-learning, whilst continuing to offer classroom session in the interim. Because of uncertainty caused by the pandemic, Clinical Risk are currently planning to deliver the interim classroom training via Microsoft Teams, whilst continuing to develop an e-learning component for future consideration.

Clinical Risk have previously delivered training for Duty of Candour disclosure. This has now been superseded by online /e-learning packages produced nationally which were made available this year. Clinical Risk have provided input into the development of these packages through workshops run by NES.

Bespoke training has also been delivered across a range of disciplines. Clinical Risk have worked with Acute Medicine in Clyde Sector to provide Risk Management training for Band 6 nurses as part of a development programme; Human Factors and Incident Management training have been provided to Oral Health including community dentistry; Clinical Risk have worked with Senior Registrars within Paediatrics to develop risk management training in preparation for taking up consultant roles.

4b: Duty of Candour

4b.1. Introduction

On 1st April 2018 the Duty of Candour Procedure (Scotland) Regulations came into force. This placed a legal requirement an all health and social care services in Scotland to ensure that when certain forms of unintended or unexpected events happen, the people affected understand what has occurred, receive an apology, and that organisations learn how to improve for the future.

NHS Greater Glasgow and Clyde has a well established principle of “being open” when patients are affected by serious adverse events. In addition to the obligations of the NHS complaints procedure the Boards Policy on the Management of Significant Clinical Incident (SCI) states that communicating effectively with patients and/or their relatives is an essential part of the SCI process. It is our aim to ensure that people affected by adverse events are treated with openness, honesty and compassion.

Every year NHS GG&C provide care and treatment to a large number of people from the Board area and

beyond, for instance there are around half a million emergency attendances. When there is a clinical opinion that we need to review the quality of care the Significant Clinical Incident Policy is used to maximise our ability to understand what happened, to share this with patients and families but above all to apply the learning to improve care. We normally complete around 250 SCI investigations per year and in the year to 31 March 2020 there were 240 Significant Clinical Incidents investigated. One of the main aims of performing an investigation following an incident is to determine if the event was in fact avoidable, which helps identify and prioritise actions that may 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? It can take time to thoroughly investigate each event, using root cause analysis, therefore at the time of reporting 114 of these investigations were completed.

Of the 114 investigations completed 90 patients/relatives were informed and invited to participate in the investigation. The organisation records and reviews whenever the patient or family was not informed to ensure we fully meet our own policy principle. The reasons for not involving included events where there was no contact with family or the investigation relates to an internal process unrelated to the patient care or outcome.

4b.2: Background

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 may incidents happened to which the duty of candour applies?

Between 1 April 2019 and 31 March 2020 there were 49 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	13
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	2
A persons treatment increased	27
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	1
A person experienced pain or psychological harm for 28 days or more	3
A person needed health treatment in order to prevent them dying	1
A person needing health treatment in order to prevent other injuries as listed above	0
Total	**49**

A Significant Clinical Incident (SCI) investigation has been commissioned for all 49 Duty of Candour incidents. At the time of writing, 34 of these investigations have concluded.

These 34 completed SCIs investigations have generated **94** actions. Please see table below for further details.

	Count	%
Number of Closed Duty of Candour applicable SCIs	34	-
Actions Generated	94	-
Actions Completed	40	43%
Actions in still in progress	54	57%

4b.4: To what extent did NHSGGC follow the duty of candour procedure?

Apologies were offered to all 34 patients either face-to-face/telephone or by letter and/or accompanying SCI information leaflet. In two cases the patients/relatives declined or did not respond. In the remaining 32 cases the patient and/or relatives were informed of the investigation and invited to contribute however in all instances completed investigation report was offered to all patients/relatives.

4b.5: Information about our policies and procedures

NHS Greater Glasgow and Clyde have implemented its Duty of Candour Policy, supported by information and guidance as well as virtual training modules and bespoke training. The clinical risk team provide advice and support to the services on the role of the duty when a significant clinical incident review is taking place, as well as providing regular reports which monitor the duty of candour process.

The lead staff in the Board are part of a national network intended to collectively work on developing the value of the Duty of Candour in the NHS. The national research of the annual reports from 2018/19 was not published or developed as a result of the national Covid-19 emergency response. The Board also considered Duty of Candour as within the escalation arrangements for the Royal Hospital for Children & Queen Elizabeth University Hospital established in November 2019. In addition the recently published Independent Review Report on Queen Elizabeth University Hospital also made recommendations on the application of the Duty of Candour as it relates to infections. As a result of the need to conclude the reviews and national research we were unable to progress an in-depth policy review as originally planned for this year. However we will continue to contribute to the national review process and ensure that any findings are integrated into local policy and practice.

4b.6: What has changed as a result

There have been a number of changes following review of the duty of candour events. The list below highlights a selection of learning being applied to improve care:

- After recognising drug toxicity in a patient it was recommended that the Clinical Management Guideline (CMG), which supports clinical decisions making, could be improved to differentiate between histological subtypes of ovarian cancer (i.e. to make a clearer distinction between different forms of serous tumours). The revised CMG also contains clearer recommendations on treatment options that are better linked to the individual patient's histology. The guideline is connected to the electronic chemotherapy prescribing system, which will provide additional safeguards to avoid similar incidents in the future.

- An initial patient assessment identified mobility issues. This information was not highlighted during a transfer to the Acute Assessment Unit. The staff who were unaware of this identified risk, relied on the patient’s personal assurance of ability, but unfortunately the patient overestimated this and subsequently fell. As a result of the investigation a review of the handover process for patients transferring to Acute Assessment Unit was required, with a clear process for transferring key information put in place. It was recommended that this includes the introduction of an allocated responsibility for admissions, so a nurse is designated each day to take communication on transfers to the unit.

- Following transfer between wards an elderly patient suffered a significant deterioration after transfer to a different ward. The observation frequency was not in line with recommended practice during the period of the transfer and was not fully recorded. As a result regular monitoring of recording quality was established, with an additional prompt to escalation of concerns was to be recorded on charts and on the patient safety board also put in place.

- A discrepancy was identified when a patient's DNA was re-tested using a new expanded test. This identified that in the past the patient had been incorrectly informed that they tested negative for a gene which carries an increased risk of breast cancer. The original test information was collated from various sources and the former reporting processes was open to the wrong patient information being used to form a report. This risk is no longer present as laboratory now use an automatic electronic system in which all patient information is held within a single electronic file allowing the scientist to open all data for a patient in isolation, minimising the risk of such errors.

- During repositioning of a patient in surgery for a clamp being used to maintain the head in a stable position was found to have damaged the patient's eye. The investigation found that during the manoeuvre the position of the pins was not always visible. As a result of a standard operating procedure (SOP) has been developed and introduced to enhance the safety of patients when such clamps are in use.

- A patient's blood thinning medicine was not stopped prior to a biopsy resulting in an urgent intervention by the radiologist to stop the bleeding. The investigation revealed that a number of staff made assumptions about others having completed the task of stopping the medicine. There is a set protocol for outpatient biopsy procedures which formally check a number of factors, including a review of medication before proceeding to biopsy. These results of the checks are now documented in a standardised checklist which has been implemented.

- The wrong operation was performed on a patient's hand. A number of the normal preventative measures did not operate, complicated by significant changes to the order in which patients were treated in theatre. As a result the service are refreshing implementation of the operative brief and pause, the marking processes and use of additional sources of information to verify the correct procedure.

5: Effective Care: Quality Improvement and Corporate Assurance

5a: Revised arrangements for Clinical Effectiveness

The Clinical Governance Support Unit was initially developed in 2005, and came into place in April 2006. At that time there were very specific practices that clinical governance support followed, and initially the unit continued with these approaches. Over the years the unit has continued to learn and adapt.

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.

5b: Support to Quality Improvement Programmes

5b.1: Deteriorating Patient

The Deteriorating Patient Steering Group endorsed the move to an exemplar ward model to be developed from April 2019 onwards. This approach aspired to be collaborative with services and clinical teams supported by a quality improvement advisor from the Clinical Governance Support Unit staff. The approach encouraged the development of multi-disciplinary improvement teams. The expectation was that knowledge and appreciation within these teams of their immediate clinical area would enable them to:

- identify areas of good practice
- highlight areas for improvement
- develop bespoke aims, measures
- generate ideas for changes to be planned, tested and implemented

Collectively this leads to improved systems and processes with regards to recognition and response to deteriorating patients and the input from CGSU staff would support the exemplar ward teams to develop their quality improvement skills in a practical setting.

The use of a non-prescriptive approach was welcomed by the Deteriorating Patient Steering Group. The application in reality presented a number of challenges for the Clinical Governance Support Unit staff supporting the nominated exemplar wards. These challenges can be attributed to:

- Limited preparation work of the nominated exemplar wards
- Assumptions about existing levels of understanding of current systems/processes
- Lack of a framework for the exemplar wards
- Difficulty in connecting the ward-level improvement work to the overarching aim: To reduce cardiac arrests in general ward settings,
- Lack of understanding of existing assurance mechanism currently in place and impact of these on improvement activities

In the period April 2019 to March 2020 a total of 23 wards were nominated and introduced to the exemplar ward approach. The progress of the participating exemplar wards ranges from those who are assessing the readiness for change within their teams to those who are actively planning and testing changes.

5b.2: Frailty at the Front Door

This programme was designed to improve the care of frail people over the age of 75 years in Inverclyde Royal Hospital (IRH) focused on the medical receiving unit, and the geriatric medicine unit (Larkfield Unit). The project commenced in July 2019, with data collection beginning in September 2019. Following two months of very complex and cumbersome reporting to the national team, the project team established a bespoke dataset which is maintained routinely.

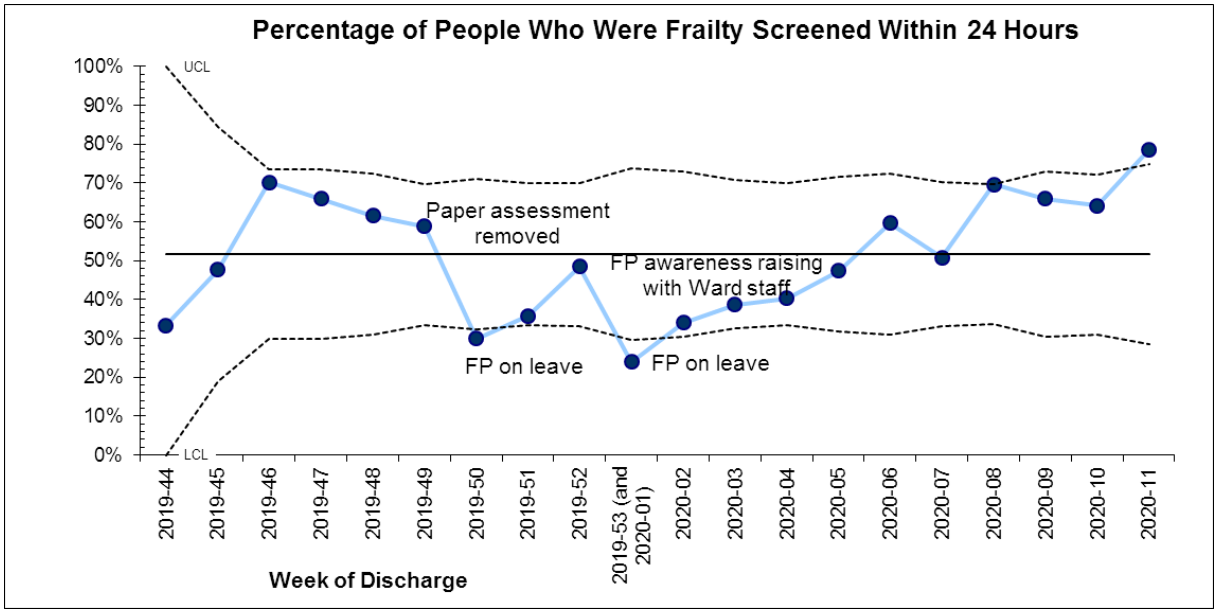
A Frailty Team was established from a network of disparate individuals working in different areas of the IRH site. Over the lifespan of the project the team has grown to include staff from the emergency department, the main hospital site, social work team and local authority care partners. Expansion of this team has helped to smooth the patient pathway, particularly when transferring into and out of hospital services.

The Larkfield Unit redesigned their processes with an aim of reducing the general length of stay and providing a more acute focused care environment. By working with the Bed Managers, the Larkfield Unit admissions are now identified by a member of the Frailty Team so that specialist beds are given to those who most need them. This has also helped to reduce the length of stay for people in hospital and reduce the number of moves that may happen during their admission.

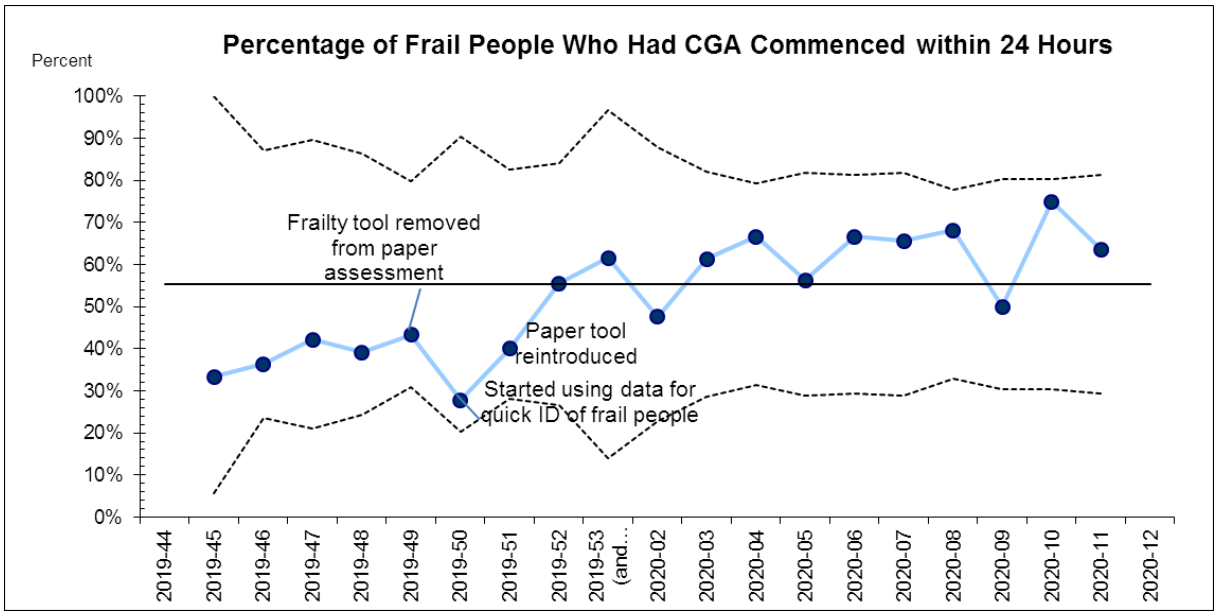
A key change idea was screening for all people over the age of 75 years. In reality, this project has raised a number of questions relating to variation in the processes to identify people receiving early Comprehensive Geriatric Assessment (CGA) and processes for identifying frailty.

On commencement of this work, Frailty screening was part of the initial assessment process. An electronic frailty screen was introduced to aid meeting the standard of completing a frailty screen within 24 hours of admission. There are 2 significant problems relating specifically to the electronic frailty tool:

- Most of the initial assessment is undertaken on paperwork, so staff may not be accustomed to using the computer record at this stage of the care process and are unfamiliar with the electronic frailty screen.
- It is not possible to locate the frailty screening tool on the computer system once the person has been discharged from hospital. This means that post discharge, you cannot determine whether the person has been screened at all.



Ongoing measurement has highlighted that the pathway is not well aligned at some points. For example, people not necessarily identified as frail had CGA, or were admitted to the Larkfield unit. This suggests that the process for identifying frail people who may require CGA is not well connected to the frailty screening process and requires further exploration.



5b.3: Maternity, Neonates and Paediatrics Quality Improvement Programme

The QI programme continues some of the work from SPSP MCQIC which began in 2012. The programme is split into three main areas, Maternity, Neonates and Paediatrics. Each of these services has a Quality Improvement Group which coordinates the workplan and has an overview of all quality improvement activity in that area.

5b.3i: Maternity

The three main GGC maternity units are working on the continued reduction of the stillbirth rate. One main aspect of this work is antenatal fetal monitoring using Cardiotocography (CTG). The main focus of this work is Positive Peer Support Reviews (Fresh Eyes) along with timely documentation of the recognition and response elements of the CTG bundle.

A project at the RAH produced a Labour Ward Guide which has been incorporated in the induction of newly qualified midwives who took up posts in February 2020 at the RAH. The Guide has been shared with the leads of the other GGC Maternity areas as well as those in NHS Ayrshire & Arran.

5b.3ii: Neonates

The three GGC units have an overall aim to reduce neonatal mortality and morbidity and are working on four core outcome measures:

- reducing Central Line Associated Blood Stream Infections CLABSI
- term admissions to neonatal units
- hypothermia
- Necrotising Enterocolitis (NEC)

The toolkit, provided by the national team at Healthcare Improvement Scotland, assists staff to use data to identify where improvements are needed.

5b.3iii: Paediatrics

Work continues to support the reduction of Rapid Admission to PICU for Inpatient Deterioration (RAPID) which is the key outcome measure within Paediatrics.

Teams are testing a new Paediatric Early Warning System (PEWS) tool which is monitored via the CAIR (Care Assurance Improvement Resource) Dashboard as well as the inclusion of an SBAR-D form in the Watchers process. The reliability of the PEWS process is currently 94% for the overall bundle and for the management of patients at risk.

A QI collaborative to reduce the rate of Central Line Associated Blood Stream Infections (CLABSI) continues. The project represents the wards where the sickest children are cared for and staff have to adapt to an ever changing clinical and physical environment often under intense scrutiny. There has been clear improvement from the mean rate per 1000 bed days of 5.3 in 2017 to a current mean of 1.8.

In September 2019, it was recognised that the Peripheral Vascular Cannula (PVC) processes are robust which led to the agreement with Healthcare Improvement Scotland
(HIS) to cease monthly data submission, and use IV Access Device SABS data collected by Infection Control for continued assurance.

5b.4: Best Start

The Best Start – A Five Year Forward Plan for Maternity and Neonatal Services in Scotland has a vision that services are redesigned using the best available evidence, to ensure optimal outcomes and sustainability, and maximise the opportunity to support normal birth processes and avoid unnecessary interventions.

In October 2019, a Lead Clinical Improvement Coordinator was appointed on a one-year contract to work with maternity teams to implement the continuity of carer aspect of the best start programme which provide women with care from the same midwife or team of midwives during the pregnancy, birth and the early parenting period. This post holder would support the application of quality improvement methodology identifying and testing changes to support the implementation of providing continuity of carer. The work started with the Maternity team in the IRH however was put on hold due to COVID-19.

5b.5: Mental Health

The period April 2019 to March 2020 was a transition phase for the SPSP MH programme in NHSGGC (and nationally): in July 2019 Healthcare Improvement Scotland (HIS) produced new guidance for health boards on the future direction of the programme, outlining new Core Measures and a new board Self-Assessment template. In February 2020, following feedback from Boards, including NHSGGC, HIS indicated there would be further changes to the Core Measures. These changes were put on hold due to COVID-19.

5b.5i: Risk Assessment & Safety Planning, Safe & Effective Medicines Management and Communication at Transition

The 15 wards participating in these three SPSP MH bundles reduced to quarterly data collection from May

2019 as they were able to demonstrate reliability in line with the SPSP MH Bundles. Data collection ceased with effect from January 2020 in anticipation of a new quality management process in line with the new MH Portfolio programme from HIS.

5b.5ii: Violence and Restraint Reduction

By October 2019 median concordance for this bundle over the 8 test wards was 98%. Ward collection of specific SPSP MH data for this bundle ceased with effect from January 2020, in anticipation of a new quality management process.

5b.5iii: Leadership and Culture

5b.5iiia: Annual Staff Safety Climate Survey

All 15 wards in the main SPSP MH programme participated in the annual Staff Safety Climate Survey during the 2019 annual cycle, with 213 staff members responding. Reported improvements made by the wards as a result of this staff feedback included:

- Enhanced communication when patients are transferred between ward areas, both by written and verbal means, by adapting and improving current systems and communication channels.
- Clinical supervision re-introduced as a supportive mechanism to all members of the clinical team
- Enhanced visibility of leadership within the ward.

5b.5iiib: Annual Patient Safety Climate Survey

All 15 wards in the main SPSP MH programme participated in the annual Patient Safety Climate Survey during the 2019 annual cycle, with 61 patients responding. Reported improvements made by the ward as a result of patient feedback included:

- Availability of information for patients on prescribed medication: in order to provide suitable information to patients, SCN disseminated an email to all trained staff with a link to pharmacy approved information leaflets. When a patient is being commenced on a new medicine, their named nurse will utilise the email link to provide appropriate information on the patients' medication.
- Implementation of 'A Positive Approach' workbook
- Weekly patient physical health monitoring
- Improved patient access to gym, exercise groups and dietician.
- Better provision of patient links with medical staff and pharmacists leading to improved understanding of medication.

5b.5iiic: Safety Conversations

SPSP Mental Health Safety Conversations (formerly known as Leadership Walk Rounds) were held to ensure that senior management are engaged with frontline teams in working together to build cultures of quality and improving patient safety.

4 Safety Conversations were scheduled and took place in 2019. As well as recognising a number of existing positive ward quality improvement initiatives, the visiting team identified the following areas in which individual wards should test further improvements:

- Introduction of ward management team meetings at least 2 to 4 times per year, with Nursing, Medical, Allied Health Professionals (AHP) and Psychology representation. Include review of staff activity levels to discuss whether multi-disciplinary team working is optimal for the activity figures in the new ward.
- Examine / review process of patient transfers to other wards to determine whether these could be reduced in number.
- Discuss possible solutions to preventing patients absconding and choose the best option for the ward to test, with the support of the local management team.

5b.5iv: Next Steps

With no current national plans in place, during 2020/21 NHSGGC will focus on local priorities in the following areas

- Testing and implementing new observation practice policy
- Review of Mental Health Assessment Units
- Evaluate remote access using Attend Anywhere

5c: Quality Improvement Capability

NHSGGC supports 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:

Type of Training	No of Current NHSGGC Staff
Scottish Quality and Safety Fellowship	33
Scottish Improvement Leaders (ScIL)	55
Improvement Advisors	5
Q Members	37
Scottish Coaching and Leading for Improvement Programme (SCLIP)	91

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.

All staff who have completed a national improvement programme are a part of the network. Members of the network are involved in the board's priority improvement programme around deterioration, maternity and paediatrics and the frailty work. Members of the network have also been instrumental in setting up Quality Improvement groups across the sectors and directorates.

5c.1: 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.
The objectives of the programme are to enable participants to increase their knowledge and skills in Quality Improvement, Coaching conversations and Leadership to support teams to deliver improvement.

NHSGGC working in conjunction with NES began delivering a local cohort of SCLIP in February 2019. A second cohort commenced in November 2019 and was completed in March 2020. This cohort had 28 participants from across NHSGGC and the six HSCPs.

5c.2: NHSGGC Scottish Improvement Foundation Skills (SIFS) Programme

SIFS is an online virtual learning programme. The aim of SIFS is to support individuals to develop the skills, knowledge, and confidence within teams to apply standard improvement methods to test, measure, and report on changes made. This is done through a blended learning approach of virtual participative learning and applying new skills to practice in real improvement efforts. Every participant in the programme will apply their new skills to an improvement project within their area. This project may be a local project or a part of a larger QI programme.

NHSGGC started testing the delivery of the programme with a cohort from the AHP Quality Improvement Programme 2020 which started in February. However, this programme was put on hold due to Covid-19.

The next steps for the SIFS programme is to scale up the delivery of the training so that there are multiple cohorts running concurrently which will give the sectors, directorates and quality improvement groups the opportunity to develop their own cohorts to link into their local QI priorities.

5c.3: NHSGGC Quality Improvement Training

Since 2014, there have been a total of 49 1-Day Quality Improvement Workshops held with another 9 half-day Quality Improvement sessions. The tables below provide a break-down of the numbers of staff who attended these sessions.

Profession	1-Day	Half-day	Total
Nursing & Midwifery	437	94	531
Allied Health Professionals	198	54	252
Medical & Dental	163	43	206
Administration	112	19	131
Pharmacy	71	8	79
Other	104	21	109
TOTAL	**1085**	**239**	**1324**

Division	1-Day	Half-day	Total
Acute	687	164	851
Partnerships	231	54	285
Corporate	160	18	178
Other	7	3	10
TOTAL	**1085**	**239**	**1324**

Further to the delivery of the QI programmes and workshops, quality improvement training was delivered to the following groups

- West of Scotland Advanced Practice for NMAHP
- Community Rehab Team in East Dunbartonshire
- IRH Frailty Team
- Nurse/Midwife Induction Session for Paediatrics and Neonatal Staff

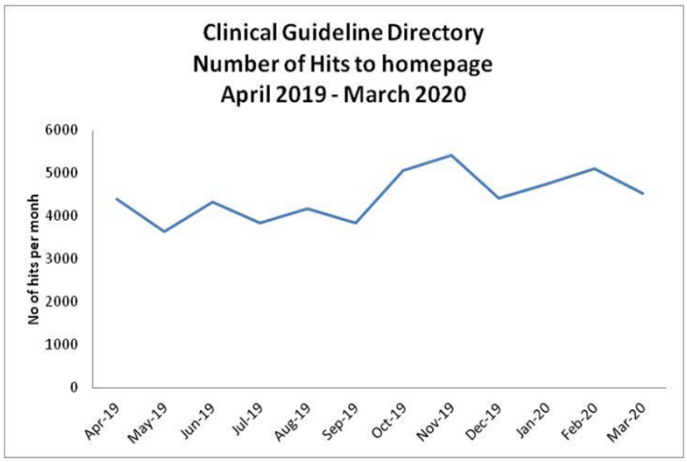
Work around quality improvement capability continues to be developed and the next steps for 2020/21 will be to develop a Quality Improvement Capability Strategy and implementation plan as well as developing a return on investment plan to measure the benefits of the QI training.

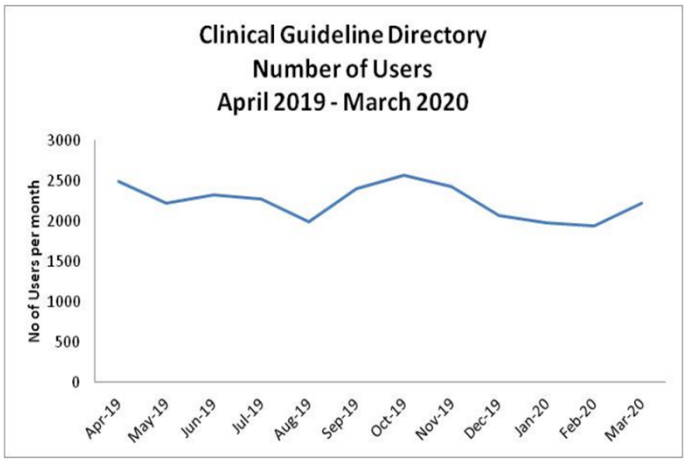
5d: Framework for Addressing Clinical Guidelines

5d.1: Overview of Process

Processes to maintain the NHSGGC Clinical Guideline Directory continue to work well, with 579 guidelines accessible on the directory. 96% of the clinical guidelines remain current and valid as at 31st March 2020.

- The Clinical Guideline Directory remains a well utilised resource with >53500 hits from 1st April 2019 – 31st March 2020, and an average of 4459 hits to the homepage each month.
- There is an average of 2239 users of the directory per month. Users of the directory range from consultants and pharmacists to ward staff.





The dosing calculators remain consistently the most accessed guidelines on the directory, the table below highlights the top 10 guidelines from 1st April 2019 – 31st March 2020:

No	Name of Guideline	No of Hits
1	Gentamicin Dosing Calculator, Adults	22721
2	Vancomycin Dosing Calculator, Adults	6190
3	Vitamin B12, treatment of deficiency in adults.pdf	3481
4	Guidance at end of life care for health care professionals.pdf	2565
5	Vitamin D prevention and treatment of deficiency in adults.pdf	2021
6	Empirical antibiotic therapy, infection management, adults.pdf	1826
7	Treatment of IDA in adults.pdf	1431
8	Diabetes management of type 2 diabetes mellitus.pdf	1210
9	Adult protected antimicrobial policy.pdf	1209
10	Hypertension management, heart mcn.pdf	1196

During 2019 – 2020, a process was introduced for new and updated clinical guidelines requiring approval from Acute Services Division Clinical Governance forum and Board Clinical Governance forum which now includes an SBAR report to be presented with the new or updated guideline which will advise the approving group of information required in order to assist them in approving the guideline, this includes;

- A list of changes to clinical advice
- Key stakeholders consulted in the development and review of the guideline
- Area(s) of applicability for the guideline
- If any local level governance groups have had oversight of the guideline

Lead authors are also asked to attend to present the guideline and explain key changes and/or answer any questions which the approving group may have. Initial feedback from lead authors suggests this is a very useful process and ensures timely approval of guidelines.

5d.2: Framework Review

The framework and directory underwent a period of consultation and review during 2019. Feedback has been collated, themed and taken into consideration.

Recent feedback from service, on the NHGGC Guideline Framework and directory, has suggested accessing the directory is the main issue users are experiencing, as it is only accessible from an NHSGGC device/ account. Feedback also advised the search function within StaffNet is outdated and provides no benefit to users.

A paper has been drafted with recommendations and will be presented to the appropriate governance groups in due course.

5e: Framework for Clinical Quality Publications (CQPs)

5e.1: Overview

Processes to track and review clinical quality publications, and to review national guidance and NICE IPGs, continue to operate well, with the number of publications *decreasing* since 2018, with 86 clinical quality publications identified for tracking between 1st April 2018 and 31st March 2019; and 68 between 1st April 2019 and 31st March 2020. Table 1 below details the type of publication identified for 2019-2020:

Table 1: Number of CQPS identified for tracking

Type	Number
Publications	23
Cancer publications*	9
National guidelines	1
HIS Standards	0
SHTG advice	7
NICE IPG	27
Good Practice Guide	1
Total	**68**

**Review and consideration of actions for all cancer quality publications is maintained via local cancer governance arrangements. Information for the purposes of this report is gathered on a quarterly basis from the Cancer Performance Lead*

A high-level overview of open clinical quality publications is reported quarterly at Division level, along with an overview of closed publications. A summary position for closed publications, along with proposed actions for the clinical governance forum is outlined. In the majority of cases, the review will confirm that the service have reviewed findings/ outliers, and an action plan is in place to take forward any relevant actions, in which case the Division is asked to note findings with no actions proposed. Where an issue, outlier or required action is identified, this is flagged to the group for consideration.

5e.2: Red flag process

The “red flag process” introduced in December 2018 has evolved during 2019-2020 to include the application of a risk rating to the red flag item. A red flag can be applied where the nature of any outliers, or of any outstanding actions or recommendations, are considered a clinical risk, or where they constitute a risk to the reputation of NHSGGC. The risk rating allows the appropriate review group to have a better understanding of the level of risk, and the priority of any proposed actions.

Reporting on open red flags has also been expanded to include the reason the red flag was applied, the date and group who identified the red flag, and a current status, which is updated every quarter until the action is closed by the appropriate group.

3 red flag items have remained open during 2019-2020 - a red flag can be applied to a publication or an outstanding recommendation/ action from a publication. The open items require West of Scotland/regional approach to allow the outstanding actions/ outliers to be addressed, e.g. strategy review, new model of care.

A risk rating process is also being tested with the publications process overall, to better inform review groups of current position and risk. This will be considered more fully as part of the framework review.
The NHSGGC Framework for Addressing Clinical Quality Publications is due for review and will shortly be sent out for consultation.

5f: Clinical Informatics

The Clinical Informatics work programme involves strong partnership working between the digital strategy arrangements, clinical governance and the Healthcare Quality Strategy. The Clinical Governance Support Unit is supporting a number of objectives within the work programme and is working with eHealth on others. A priority objective for the CGSU within this programme is the development of a set of measures that support corporate oversight of healthcare quality in NHS Greater Glasgow and Clyde. The key principles in doing so are:

- To improve access to meaningful data, with clarity of the data purpose and robust interpretation of what it tells us about our system.
- To understand variation within the system and to build appropriate action planning for different types of variation, whether natural or special-cause.
- To allow for benchmarking against what we, as a Board, determine to be a high standard.
- To create the conditions in which this data can facilitate decision making at different levels i.e. providing corporate assurance for action planning, but also for improvement at a clinical level.

The Clinical Informatics branch of the CGSU has made good progress with this work stream so far, already achieving the following:

- Over 200 potential indicators have been identified from a wide range of sources
- Developing good relationships with clinical teams and committees around this work, particularly thrombosis committee, maternity services, medicines team and the Scottish Trauma Audit Group at the GRI.
- Growth within the team with a new data analyst who has been working tirelessly to develop dashboards in excel which will allow us to showcase ideas to clinical teams going forward and help with engagement.
- Work has started on exemplar projects with the above teams to showcase the difference that dynamic data can make to projects, and these will be progressed further throughout the coming year.

5g: Clinical governance reviews

In 2020, the Acute Services Division Clinical Governance Forum developed a programme for clinical governance reviews. A 6-monthly review meeting will take place between sectors/ directorates and the clinical governance team. The meeting provides an opportunity to discuss clinical governance arrangements and processes, to provide key updates, and to identify any potential areas of good practice, or issues to be escalated or addressed.

Key points from each review are captured and will be used to provide a high level summary report of strengths/ best practice, challenges/ at risk areas, and of any actions/ improvement recommendations across the Acute Division. This can be used to inform the work plan and priorities for the Forum overall.

5h: Datix

The Risk Systems (Datix) team continue to provide end users with an application support function,

responding to and resolving over 5000 requests from service in 2019/20. This ranges from user provisioning, generating and setting up reports, to providing data in response to Freedom of Information requests.

In addition, the team works on a range of projects, and with key stakeholders across the service, to both maintain the system, and to improve data quality and reporting. Some key projects undertaken during 2019/20 are outlined below:

5h.1: Contract Renewal and Procurement

The support and maintenance contract with Datix has been renewed until May 2021. A SLWG has been convened to develop a national framework contract for an Integrated Risk, Incident management and Patient Safety system. The Risk Systems Manager has a key role in supporting the SLWG.

5h.2: Datix Support, Infrastructure/Developments and System **Modules**

5h.2i: System set up and permissions

A targeted piece of work was undertaken by the Datix team, working with colleagues across the services, to ensure accurate permissions were recorded on Datix, to reduce the volume of incidents being reported which were not immediately notified to an incident reviewer. System reconfiguration and communication to users has seen a significant improvement in the data. Engagement continues to be made with services to identify reviewers and approvers where gaps are identified.

The NHSGGC Incident Management Policy states that incidents should be reviewed and submitted for approval within 7 days. A proposal to reduce the volume of overdue incidents across the most affected sectors and directorates was supported by the Datix Governance Group and CMT. Progress updates have been provided to Acute Directors and the Chief Officers. At the time of writing gradual progress is being made to reduce these, this will continue to be monitored and highlighted to service.

5h.2ii: Risk Register

There is variation in recording Risks using the Datix Risk Register module across the organisation. A proposal to reconfigure the module to ensure greater visibility of risks and accurate reporting was approved by the Datix Governance group. Engagement with the Interim Chief Risk Officer has offered further opportunity to refine the system guidance and support a proposed relaunch of the updated Risk Register policy and the module. An eLearning module has been developed to further support colleagues in its use.

This change was scheduled for implementation in March 2020 however, it had been put on hold because of the Coronavirus outbreak. Approval will be sought from the appropriate governance groups to implement the changes as we move into the next phase of recovery.

5h.2iii: Complaints

Partially upheld and upheld nursing complaints are an Excellence in Care quality indicator. The team engaged with the Boards Complaints team and Excellence in Care lead to capture the additional data elements required to deliver this. This data now feeds into the Care Assurance and Improvement Resource (CAIR) dashboard that allows users to view and understand data, respond appropriately and plan improvement as required.

5h.2iv: Legal Claims

The team worked with the Legal Claims department to redesign and update the legal claims dataset. These changes supported service improvements to existing and new business processes and provide improved management reporting. Feedback from the legal claims team on the changes have been highly positive.

5h.2v: Radiotherapy BWoSCC

Historically the BWoSCC reported radiotherapy adverse events on QPulse. In line with the incident

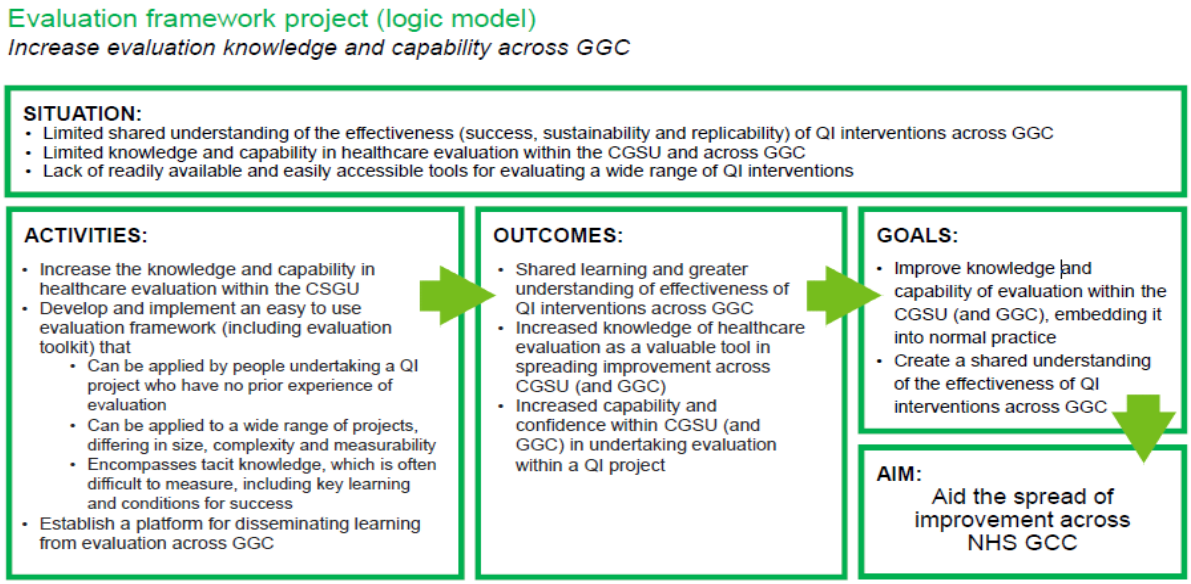
management policy and to provide overarching management visibility, the team engaged with the heads of Therapy Radiography and Radiotherapy Physics to fully understand the scope and complexity of their reporting requirements. This resulted in two new specialties being added to the system and a new category with associated subcategories to allow accurate reporting and review of events. This was trialled by the service in the test environment before implementing live in 2020.

5h.2vi: Adult Support & Protection

Working with the ASP lead the data set on Adult Support & Protection was updated, to better support colleagues who are concerned a patient is at risk of harm under the terms of the Adult Support & Protection Act. Links to a Decision-Making Checklist, a Wallchart with a Guidance Flowchart and the Referral form were all added to the system.

5i: Learning, Evaluation and Networking

Learning, Evaluation and Networking as a broad theme has become a key work area for the CARE team, with specific objectives to develop an evaluation framework and to carry out evaluation projects for larger programmes of work. Alongside this, is the development of the networks and structures to share the learning from evaluation to aid the spread of improvement.
The following figure displays the logic model for the evaluation strategy development within the CGSU and across GGC.



This will be a major strand of work for the CARE team over the next year.

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."[1]

6a: Team remit and aim

Care experience is a key component of how we define quality care. This is acknowledged as a **priority in the Scottish Government 2020 Vision, the Healthcare Quality Strategy for Scotland** (2010) and is included as a key objective in the **NHS GGC Healthcare Quality Strategy** (2019).

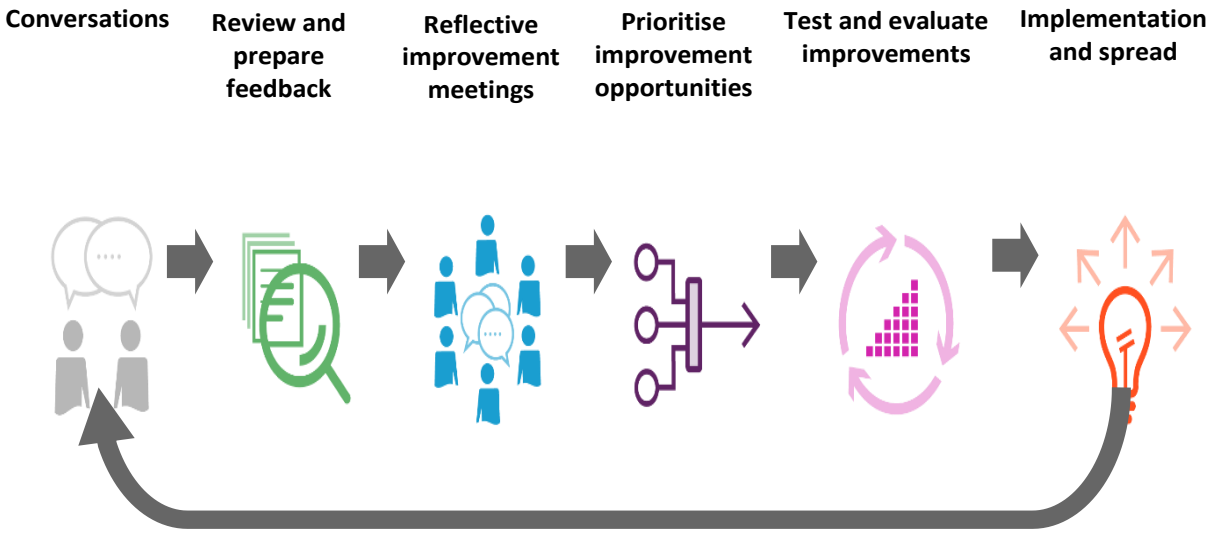
The main remit of the Person-Centred Health and Care (PCHC) Team in NHS GGC is to gather care experience feedback in 'real-time' from people receiving care or support close to or during their episode of care for the purposes of reflection, learning, improvement and whenever possible early resolution of individual issues and concerns.

The method of listening to the care experience of people is through a locally developed process described

as a **"themed conversation"**. The enquiry concentrates predominantly on gathering and developing feedback about **'what matters while people are receiving care'** and their experience of the **person-centred principles of care giving**. The feedback where possible is benchmarked against the **Excellence in Care/Care Assurance System** (EiC/CAS) **standard for person-centred care** and to the **NMC Code** - Professional standards of practice and behaviour for nurses, midwives and nursing associates (2018).

Once the care experience feedback is gathered, the care team receives support from the PCHC Team to review and analyse the feedback and identify areas of excellence to celebrate within the team as well as prioritise opportunities for improvement. Thereafter, coaching and mentoring support is available from the person-centred improvement coordinator, to help care team staff take forward improvement actions and interventions. This is referred to as the **'Care Experience Improvement Model'** and demonstrated in figure 1.

Figure 1: Care Experience Improvement Model



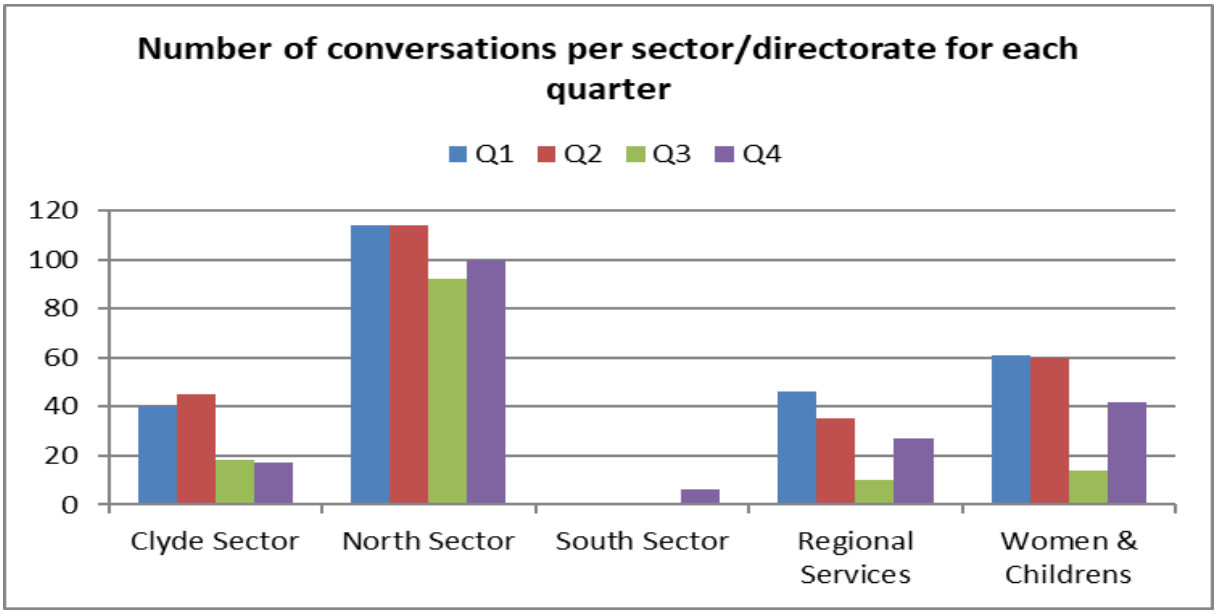
6b: Summary of key achievements – Care Experience Improvement Model

During this reporting period the PCHC Team have gathered feedback and supported improvement activity in approximately 18 care teams across five acute sector/directorates. In addition, the team were commissioned in December 2019 to work specifically with; the haemato-oncology team in the ward 6A and 4C at the Royal hospital for children following the reported infection control issues and the impact of this on the experience of children, their parents and guardians. In February 2020, a further commission requested the team to work with the clinical team in the Immediate Assessment Unit at the Queen Elizabeth University Hospital following quality of care issues raised. A separate report is available for the RHC. Unfortunately, the work at QEUH was halted in March due to the Covid-19 pandemic.

6b.1: Number of Conversations

From 1 April 2019 – 31 March 2020 **eight hundred and forty-one (841)** care experience conversations were held across five acute sector/directorates. **Graph 1** demonstrates the breakdown of conversations per sector/directorate for each quarter.

Graph 1: Number of conversations per sector/directorate per quarter

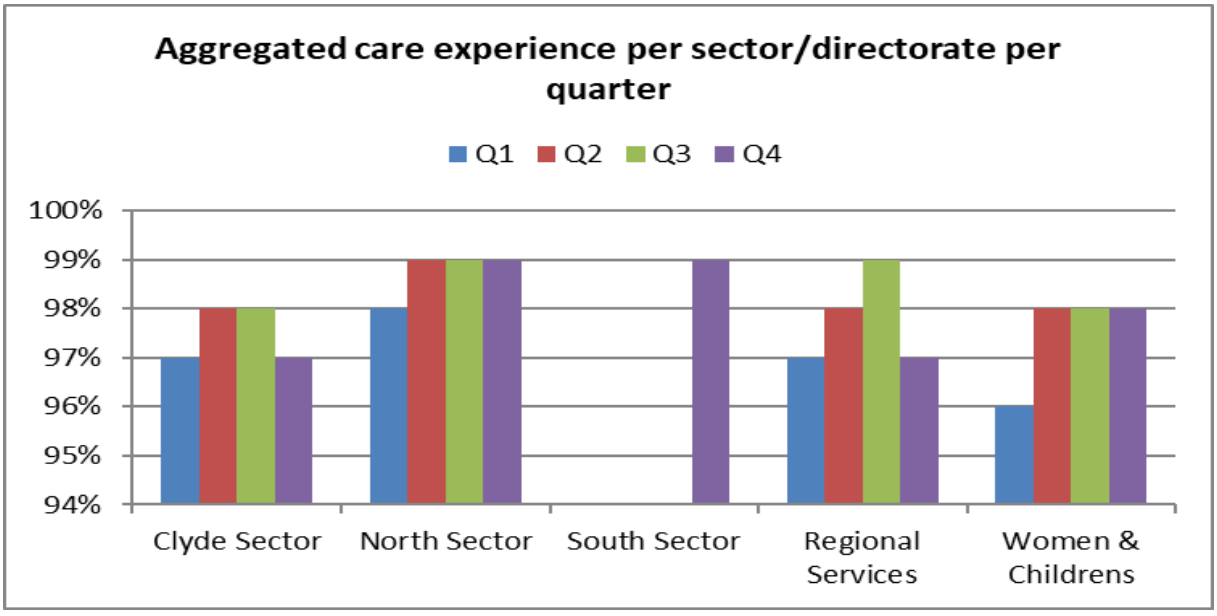


6b.2 Overall Aggregated Care Experience Response

The **overall aggregated care experience response** ranged from **96 - 100% (median = 98%)**. 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. It should be noted, care experience feedback using this model only commenced in the South Sector within Quarter 4.

Graph 2 demonstrates the breakdown of the overall aggregated care experience for each sector/directorate per quarter. There is some small variation across the sector/directorates in each quarter. However, it is worthy to highlight the aggregated care experience is consistently maintained above 95% in each quarter in each of the sector/directorates in accordance with the aim set with care teams.

Graph 2: Aggregated care experience per sector/directorate per quarter



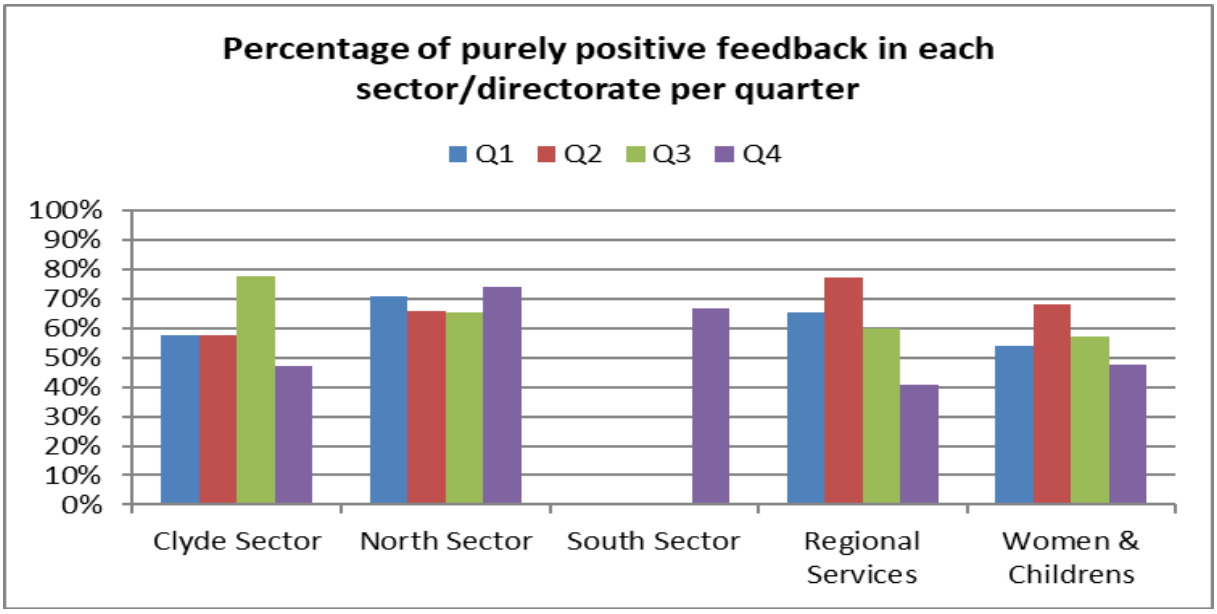
6b.3: Percentage of purely positive feedback

The percentage of people who responded positively to all the enquiry questions ranged from **45 - 100%**

(median = 68%, n = 562). It is encouraging the number of people who respond positively to all enquiry questions is at least two-thirds of those interviewed. This gives some indication that it is possible to achieve a high quality of care experience for patients and families.

Graph 3 demonstrates the breakdown of purely positive feedback conversations per sector/directorate and the random variability across each quarter.

Graph 3: Percentage of purely positive feedback in each sector/directorate per quarter



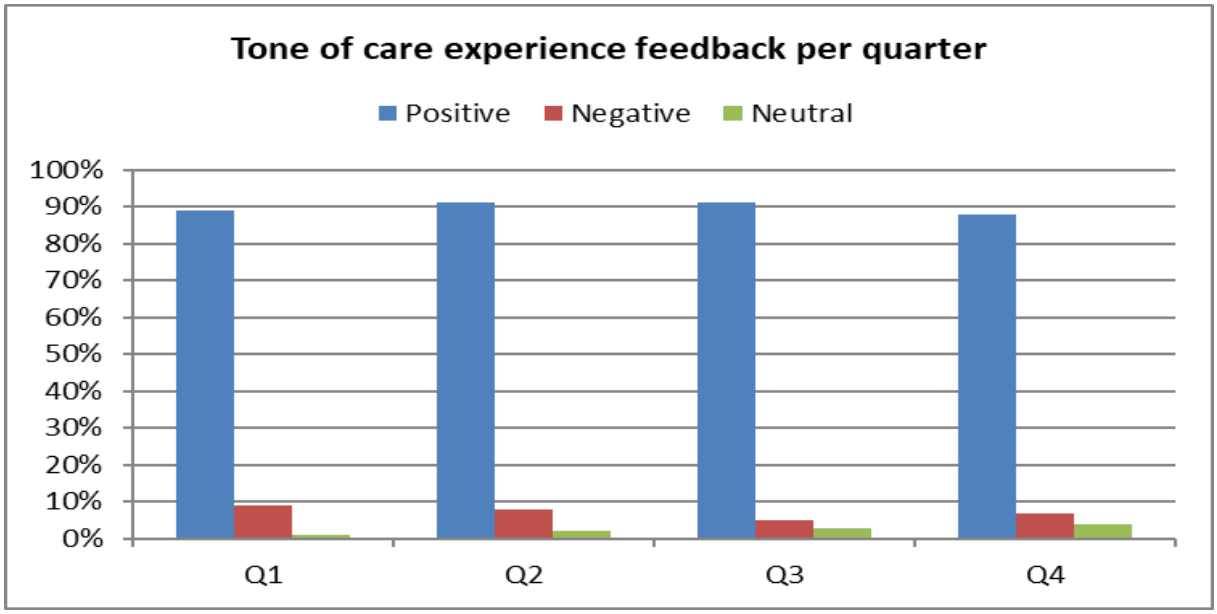
When asked *'**Would you feel comfortable if a friend or family member (or the child of a friend or family member) was admitted to this ward/unit if they needed similar care or treatment?**' **99%* **(n =833) responded positively**. This provides a high level of confidence the people interviewed are comfortable to return to the same service for future care.

6b.4: Tone of care feedback gathered

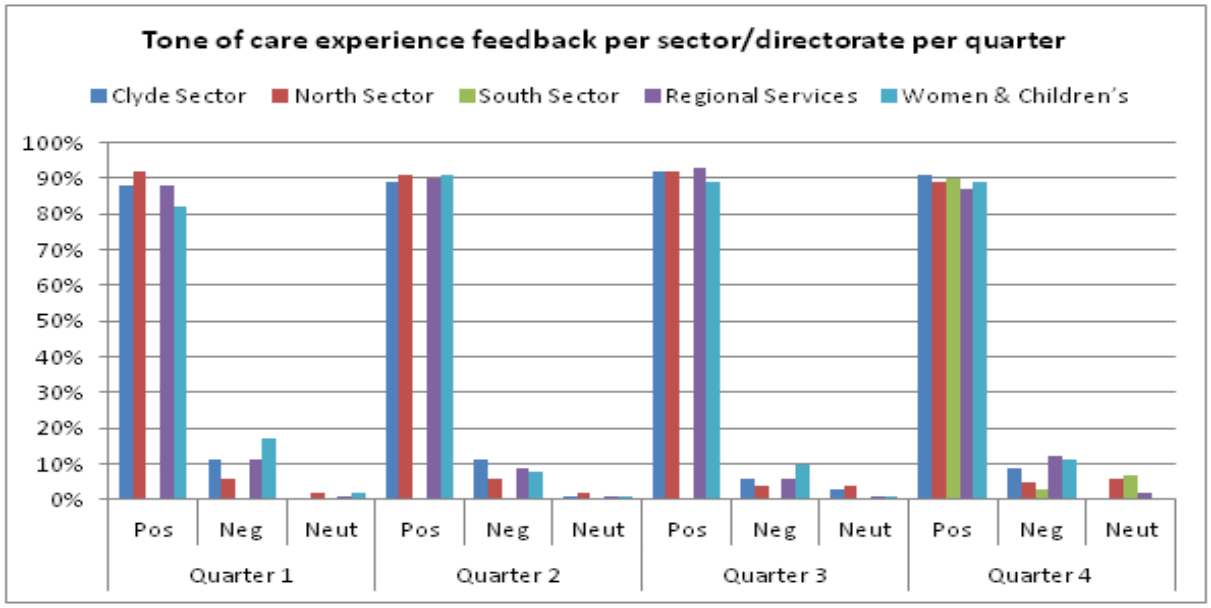
Six thousand and forty-two (6042) narratives (qualitative summaries) have been collected. **90%** (n = 5429) had a positive tone, **8%** (n = 457) had a negative tone and **2%** (n = 156) had a neutral tone.

Graph 4 demonstrates this broken down into each quarter. This shows a consistent pattern to the feedback reported each quarter with little variation in the tone over the course of the reporting period. A similar pattern is reflected when the data is further broken down into the sector/directorates. This is demonstrated in **Graph 5**.

Graph 4: Tone of care experience feedback gathered per quarter



Graph 5: Tone of care experience per sector/directorate per quarter



6c: Summary of key learning from the themes and sub-themes to inform improvement

The qualitative narrative feedback gathered in the care teams by the PCHC Team is designed to provide actionable knowledge to help guide care teams to:

- Direct improvement actions and behaviours using a targeted and informed approach,
- Develop understanding about what matters and what is valued most to the patients and relatives/carers in their care,
- Develop learning of what practice and behaviours work well and the value derived from this by patients, relatives and carers, and
- Develop understanding about what practice and behaviours need reviewed and where improvements need to be concentrated.

Analysis of the qualitative narratives provides a broader view of themes to celebrate good practice and behaviours (positive tone) as well as identifying defects and gaps (negative feedback) for further reflection and improvement. This is summarised in **Table 1**.

Helping care team staff to recognise factors, which create the conditions to achieve high quality care experience, is a key feature when reviewing and analysing the feedback. Designing improvement approaches to help sustain reliability of these positive practices and adoption of intentional positive behaviours as well as reducing unnecessary variations in practice and behaviour is vital to the success of sustaining improvement.

Analysis of the care experience feedback conversations gathered demonstrates many positive examples of the **strong therapeutic relationships**, which exist between the direct care team, patients and relatives.

Where defects or gaps in person-centred practices and behaviours arise in the care experience feedback these commonly appear to be individual isolated issues, which are variable in nature and context rather than systemic issues requiring an iterative improvement approach.

Where defects and gaps in person-centred practices and behaviours arise, the direct care teams are supported to be responsive to act on these issues immediately. When the issues are out with the direct team sphere of responsibility, escalation via the appropriate leadership and managerial structure for their action, advice and guidance is progressed in a timely and informative manner.

The collection of feedback has provided a plethora of opportunities for team reflection, learning and improvement discussions. Where required further detailed discussion has been progressed to link actions and interventions where appropriate with the use of structured improvement methodologies and testing to ensure reliability, consistency and a quality approach is achieved and embedded in practice.

Care teams commonly assume care experience feedback will be negative and are pleasantly surprised that more than 75% of what people experience is positive. Sharing the positive nature of the feedback is vitally important across the whole team to boost staff moral and acts as a natural improvement catalyst in itself as well as helping to ‘nip negative feedback in the bud’.

When negative feedback is received, it is important during the reflective improvement meetings to correlate this with other quality metrics, which are available for the ward/service, and take cognisance of any challenges, which present within the workforce resource, which may have an effect on the care experience gathered.

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. These inconsistencies are evident in several of the sub-themes within the qualitative analysis. This is demonstrated in **Table 1.**

Concentrating on raising awareness of the importance of the behavioural and relational aspects of care giving alongside the technical aspects of care is crucial to achieving a positive care experience for the people we care for.

Table 1: Analysis summary of the positive themes/sub-themes to celebrate good practice and behaviours (positive tone) and negative themes/sub-themes of defects and gaps in practice and behaviours (negative tone)

Main Themes	Positive Sub-themes of good practice and behaviours	Percentage Positive	Negative Sub-themes of gaps in practice and behaviours	Percentage Negative
Pre-admission Experience	pre-admission information	45% (n = 204)	pre-admission information	63% (n = 15)
	referral and transfer process	28% (n = 125)	information about the referral and transfer process	33% (n = 8)
	pre-admission assessment	27% (n = 121)		
Consistency and Coordination of Care	introduction and welcome received from staff	36% (n = 359)	introduction and welcome received from staff	30% (n = 23)
	symptom control and	33% (n =	symptom control and	30% (n = 23)

Main Themes	Positive Sub-themes of good practice and behaviours	Percentage Positive	Negative Sub-themes of gaps in practice and behaviours	Percentage Negative
	comfort	332)	comfort	
	inter-disciplinary working	9% (n = 92)	inter-disciplinary working practice	12% (n = 9)
Communication and Involvement in Care	feeling involved and informed of the plan of care	28% (n = 256)	family and carer involvement in care provision	42% (n = 42)
	involvement of family and carers in communication about care	19% (n = 176)	not feeling listened to	16% (n = 16)
	clear explanation about care and the opportunity to ask questions	17% (n = 152)	not feeling involved and informed of the plan of care	15% (n = 15)
Respect and Dignity	attitudes and behaviours of staff	44% (n = 393)	attitudes and behaviour of staff	46% (n = 31)
	personal care provided respectfully, in a dignified manner	19% (n = 169)	respect for values and preferences	21% (n = 14)
	respect for spiritual and emotional needs	14% (n = 129)	respect for spiritual and emotional needs	15% (n = 10)
Safety	staff competence with clinical care	43% (n = 374)	response to calls for assistance	40% (n = 17)
	check-in frequency (care rounding) and visibility of staff	22% (n = 188)	check-in frequency (care rounding) and visibility of staff	19% (n = 8)
	access to a call buzzer to call for assistance	10% (n = 90)	competence in clinical care	19% (n = 8)
Environment and Facilities	visiting experience	40% (n = 314)	environment and facilities being appropriate for need	53% (n = 58)
	clean environment	23% (n = 180)	activities and stimulation	15% (n = 16)
	environment and facilities appropriate to their need	17% (n = 131)	absence of a calm and pleasant environment	12% (n = 13)
Mealtime Experience	choices of food and drinks offered	77% (n = 354)	choices of food and drinks offered	73% (n = 45)
	quality of the mealtime experience	14% (n = 64)	quality of the mealtime experience	24% (n = 15)

6c.1: Best Practice and Improvement Examples

A number of **best practice and improvement examples** tested and implemented within the care teams are summarised below:

Patients attending the urology pre-operative assessment clinic at GRI receive a series of information leaflets explaining what will happen at each stage of the procedure. This allows patients to read at their leisure the information and prepare in advance any questions they have for their Consultant or Clinical Nurse Specialist. This has been consistently reported by patients as a helpful and positive experience in their feedback in ward 70, GRI.

In ward 6A, Royal hospital for Children a ward information pack has been introduced for children and their parents, which includes information about the routine of the ward and explanation about why things need to happen in a particular way.

In ward 26/27 at Glasgow Royal Infirmary, the importance of introductions and welcomes when meeting patients for the first time is recognised as a key part of building relationships with patients and their family.

A “#Hello My Name is.....” poster is visible in each patient room which is completed at the beginning of each shift after the nurse has introduced themselves. The poster helps patients and their families to identify which nurse is looking after them and reminds them of a name to ask for if they have any questions and queries. This has helped patients to identify with one key member of staff on each shift to request information and discuss their plan of care.

During each meal service nursing staff in Ward 7 Royal Alexandra Hospital focus on supporting encouraging and helping patients have a positive experience. Prior to mealtime service the staff discuss their choices checking if this is still their preference, updating the ward catering assistant who provides guidance on alternatives. All patient bed tables are cleared and cleaned before the meals arrive. Patients are offered a choice of cold drinks and encouraged to practise good hand hygiene prior to meal service. Meals are offered standard or small plates to address changes in appetite, with staff discussing their preference at each meal. This helps to avoid unnecessary food waste, and allows other patients to be offered a little more if required. The catering-assistants strive to ensure food is presented well and in accordance with preferences requested, as patients have said they are often put off with a plate full of food. This way of working supports staff to be vigilant when patients are off their food to address concerns without delay as well as respecting ‘**what matters’ & ‘what’s important’ to patients during mealtimes**.

‘What matters to you?’ boards and pictures are a key aspect to providing person-centred care and an important communication tool to find out what is most important to a child when they are in hospital, their key interests and snippets of information about who they are. Feedback in Ward 6A, Royal Hospital for children highlighted a more rigorous approach was required to ensure completion of these for every child. Ward staff now routinely approach each child as soon after admission as possible to offer the opportunity to draw a picture to convey what is most important to them while they are in hospital. This is then used, as a focal point for discussion with the child and their parents during all interactions to ensure what is important to them is a central feature of every care process.

Ward 3C Royal Hospital Children, staff identified there was a gap in capturing the accuracy of activity of some children overnight when parents are providing personal care. **‘Night-Time Notes’** were tested to provide a tool to allow the parent/carer to record at hourly intervals, behaviours, fluid intake/ output and emotions displayed as well as the ability to highlight concerns or queries. The initial test document evolved through many iterative changes. Although initially being considered as an extra piece of paperwork, nursing staff quickly found it to be useful. They reported to find it ‘an invaluable resource of information which provides the MDT with more accurate information about overnight activity’. They now realise the gaps which existed in their communication processes and the vital information and updates that were missing which could compromise the safety of care provided’. When talking to parents about the introduction of the notes they shared the following: ‘it’s a really good idea as I’d been writing things down overnight on whatever I could get my hands on; this has been a great thing for parents and anything that gives staff more information I’m sold’.

Ward 26/27 GRI have introduced a multi-disciplinary approach to patient discharge. The Physiotherapy and Occupational Therapy Team regularly liaise with family members around discharge of patients to ensure a safe and effective discharge. An **Estimated Discharge Date** (EDD) is recorded on a **‘Shared Goal Form’** and is displayed on a laminated sheet at each patient bedside. This enables family/carers to see the planned discharge date and highlight the shared goal for each patient. The form advises relatives if they have any questions to speak to a member of staff. The EDD and goals are amended/confirmed as patient’s progress towards their discharge dates. In early March before the covid-19 visiting restriction came into place, the team introduced a 3pm bedside huddle where the Nursing, Physiotherapy and OT Team include the patient and family in a discharge planning discussion to highlight any issues needing addressed to ensure a seamless discharge occurs for all patients.

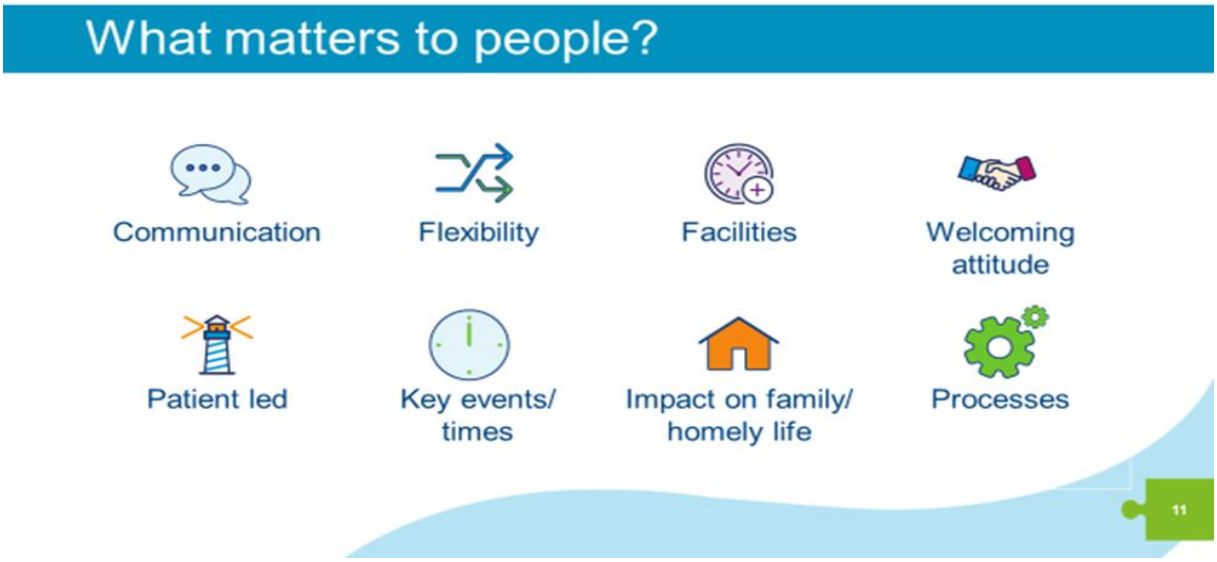
6d: Implementation if a person-centred approach to visiting

There is growing recognition of the importance of encouraging and supporting people to stay connected to the people that matter most in their lives whilst they are in hospital. To support this, NHSGGC are implementing **core principles** for Person Centred Visiting (PCV) in all 291 inpatient wards:

This is in line with the Scottish Government's ambition to have PCV in all hospitals by 2020, as outlined as a specific commitment in the programme for Government 2018-19. In NHSGGC, the executive team has endorsed this approach as one of the key priorities for 2019/20, linked to the Board's **Healthcare Quality Strategy.**

A Quality Improvement approach has been adopted to implement PCV in NHSGGC. This is organised into three main phases:

6d.1: Phase 1 – Scope and engage



In Summer 2019, we heard from over 500 patients, families and staff about their experiences of visiting; what was already going well, what challenges there might be, and how we might make this happen. A report summarising this phase is available here. The diagram below illustrates the themes from what people told us what mattered to them that we consider when implementing PCV:

6d.2: Phase 2 – Develop and Test

In Autumn 2019, we worked with around 70 wards to develop and test three key changes:

1. **Welcoming behaviours:** the people who matter to our patients feel welcome
1. **Admission processes:** talking to the patient and their family on admission about visiting
2. **Privacy and dignity:** staff feel confident and competent in asking family members to leave the room when required.

A report on this phase is in development and will be available shortly.

The diagram on the right is an example of one change that was developed and tested, namely a ward routine sheet intended to help patients make informed choices about what times they would like family with them:

However, learning from the test phase was that some people interpreted this to mean instead that there were many times when family members would not be welcomed; this therefore led to further improvements and the development of a different leaflet.

6d.3: Phase 3 – Implement and spread

Based on the learning from these tests, we were consolidating our approach in order to:

- Speak to patients, visitors and staff in approximately 50% of inpatient wards to support understanding of how well PCV is embedded, and support further improvement
- Work with leaders and managers throughout NHSGGC to support them to implement and spread PCV in their areas of responsibility
- Finalise the communications resources, campaign and approach needed to ensure PCV is embedded throughout NHSGGC.

“At the beginning I totally wasn't for Person Centred Visiting and felt very resistant to it being implemented into Receiving. I have 110% come around to the idea of this now and can see the benefit for patients. I feel we were always good at allowing visitors in to see patients out with visiting set times but think we are now much more aware of this process for all our patients. I think the important thing is to explain to patients what it actually means and ensure visiting is at a time that suits the patient and their needs.” ***Nurse in Acute Medical Receiving Unit, Glasgow Royal Infirmary***

6d.4: Update: the impact of COVID-19 on PCV

In March 2020, it was deemed necessary to restrict hospital visiting across Scotland to this only being permitted in exceptional circumstances. The implementation of PCV was subsequently paused, pending lifting of these restrictions.

During this unprecedented time, it was therefore vital that we continued to find ways to support patients to maintain contact with the people who matter most to them. Whilst the majority of people will have their own phone or tablet, there are those who do not have access to this technology and are therefore more vulnerable to isolation, loneliness and not being able to access support from loved ones.

With support from Endowments, Glasgow Life, members of the public and voluntary organisations, around 600 iPads were provided for all inpatient wards across NHSGGC by eHealth, to support patients to stay in virtual contact with the people who matter most to them.

7: Conclusion

As described in the introductory section this report can only provide insight to a small sample of the overall 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.

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