NHS Greater Glasgow and Clyde	**Paper No. 21/70**
Meeting:	**Board Meeting**
Meeting Date:	**26 October 2021**
Title:	**NHSGGC Clinical Governance Annual Report 2020-2021**
Sponsoring Director/Manager	**Dr Jennifer Armstrong, Board Medical Director**
Report Author:	**Geraldine Jordan, Director of Clinical and Care Governance**

1. Purpose

The purpose of the attached paper is to present the Clinical Governance Annual Report for 2020-2021 to the Board members for assurance.

2. Executive Summary

The paper can be summarised as follows:

Each year NHS Greater Glasgow & Clyde 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.

3. Recommendations

The NHS Board are asked to note the Clinical Governance Annual Report 2020-2021.

Response Required

This report is presented for assurance.

4. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows: *(Provide a high-level assessment of whether the paper increases the likelihood of these being achieved.)*

- Better Health Positive
- Better Care Positive
- Better Value Neutral
- Better Workplace Positive
- Equality & Diversity Positive
- Environment Positive

5. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity:

Illustrative examples within the report provided by services, information provided by the Clinical Governance Support Unit and engagement with Acute, Mental Health, Primary Care Divisional Clinical Governance and Board Clinical Governance Forum.

6. Governance Route

This paper has been previously considered by the following groups as part of its development:

Presented to the Board Clinical Governance Forum in August 2021.

Approved by the Clinical and Care Governance Committee in September 2021.

7. Date Prepared & Issued

Date Prepared: 24/09/21

Date Issued: 19/10/21

NHS
Greater Glasgow and Clyde

Clinical Governance Annual Report

APRIL 2020 – MARCH 2021

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1 Introduction

1.1 What is this report for?

Each year the Board provides an annual report describing its clinical governance arrangements and the progress it has made in improving safe, effective and person-centred care.

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

2 Clinical Governance Arrangements

2.1 Clinical Governance in NHS Greater Glasgow and Clyde

NHS Greater Glasgow and Clyde's mission statement is to:

"To protect and improve population health and wellbeing whilst providing a safe, accessible, affordable, integrated person centred and high quality health service."

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.

Figure 2.1 – Clinical Governance structure flowchart

The Board Medical Director is the Executive Lead for Clinical Governance and the Board Nurse Director is the Executive Lead for Healthcare Quality Strategy.

The Clinical and Care Governance Committee and Board Clinical Governance Forum receives reports from the key service areas as well as a range of thematic reports on issues relating to clinical safety, clinical effectiveness and person-centred care which includes feedback and complaints and the wider patient and carer experience perspective. 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 (HSCPs), 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.

2.2 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:

- Clinical Governance During Surge Report
- Clinical Risk Management Reports

- Public Protection Update
- Prison Healthcare Update
- Clinical Effectiveness Report
- Scottish National Audit Programme (SNAP) Update
- Hospital Standardised Mortality Ratio (HSMR) Update
- Mental Health Update – Including Review of Mental Health Clinical Governance Structure and Mental Health Assessment Unit Updates
- Acute Services Update – Including Unscheduled Care Update
- HSCPs Primary Care Update – Including Community Assessment Centre (CACs) and GP Out Of Hours Updates
- Pharmacy Service Update
- Controlled Drugs Accountable Officer Report
- Research & Innovation Update
- Feedback from Clinical & Care Governance Committee
- Infection Control Summary – Healthcare Associated Infection Reporting Template

2.3 Clinical Governance arrangements during the surge in COVID-19 infections

In response to the surge in COVID-19 infections, a paper on maintaining Healthcare Quality/Clinical Governance monitoring and reporting arrangements across NHSGGC was presented, and accepted, by the Board's Strategic Executive Group (SEG). It proposed that COVID-19 specific healthcare quality and clinical governance matters would be reviewed by the Tactical Groups, with regular reporting to SEG. Non-COVID-19 related healthcare quality and governance matters would be reviewed by the Board Clinical Governance Forum (BCGF) and onwards to the Corporate Management Team.

Meetings of the Board, Acute and Mental Health Clinical Governance groups were maintained, but with a shortened focused agenda where necessary. The Primary Care and Community Clinical Governance Group meetings were temporarily suspended, with the Health & Social Care Partnerships Tactical Group taking on responsibility for COVID and non-COVID oversight of healthcare quality and clinical governance. As of March 2021 the Primary Care and Community Clinical Governance meetings have resumed and all committees have now been established again.

The Clinical Governance Support Unit (CGSU) maintains links with the Division Clinical Governance chairs to provide regular reports to BCGF on key clinical governance and clinical risk matters.

3 Key messages

Safe Care

- The usual clinical risk management arrangements were maintained within the board throughout the period from April 2020 to March 2021.
- A review of the Policy on the Management of Significant Adverse Events was concluded and the new policy implemented.
- There were 42 incidents where Duty of Candour applied.
- Datix is the NHSGGC integrated incident, risk management and patient safety system. The support and maintenance contract with Datix has been renewed until May 2022 while a full Outline Business Case is being developed for a replacement system.

Effective Care

- Engagement with Acute, Mental Health and Primary Care Divisional Clinical Governance chairs is underway to identify priorities for quality improvement programmes following suspension due to COVID-19.
- Development of Quality Improvement (QI) Capability within NHSGGC progressed which includes delivery of virtual QI training courses.
- Clinical Governance Support Unit (CGSU) continues to manage the update of clinical guidelines. A process has been implemented for managing time expired guidelines.
- Processes to track Clinical Quality Publications are being maintained. New process for the review and reporting of Scottish National Audit Programme (SNAP) publications was introduced in 2020 and was commended by SNAP.
- Development of an evaluation toolkit to support NHSGGC evaluation strategy is underway.
- A suite of dashboards has been designed and built for testing which includes Hospital Standardised Mortality Ratio (HSMR), Sepsis and Venous Thromboembolism (VTE).

Person-Centred Care

- The Person-Centred Health and Care team have implemented a board-wide approach to support Person-Centred Virtual Visiting (PCVV) in all clinical areas during COVID-19. This has provided the opportunity to maintain; where possible the pivotal role family members and those closest to the patient normally play in supporting patients.
- Between March 2020 and August 2020 the PCVV service was implemented in 314 locations across 19 sites in NHSGGC.
- During COVID-19, visiting arrangements in all our in-patient hospitals has been underpinned by local guidance and risk assessment based on the national 'Visiting Guidance for Hospitals in Scotland.'
- The Person-Centred Care Planning Improvement Group and Person-Centred Steering group remained suspended due to COVID-19 clinical pressures. Both groups are scheduled to recommence in May 2021.

4 Safe care

4.1 Summary of Key Achievements

Safe care: Key Achievements 2020/21

- Review of the Policy on the Management of Significant Adverse Events.
- Increased support for Significant Adverse Event Reviews (SAER) during the pandemic from the Clinical Governance Support Unit.
- Redesign of Root Cause Analysis training to enable virtual delivery.

4.2 Introduction to Clinical Risk Management in NHSGGC

For the majority of patients requiring healthcare, NHSGGC provides high quality healthcare that is person-centred, effective and safe. In line with the experience of all healthcare systems across the world, on occasion patients will suffer harm whilst being cared for. NHSGGC seeks to minimise the frequency and degree of such instances of patient harm through an approach collectively described as clinical risk management.

"**Clinical risk management** specifically is concerned with improving the quality and safety of healthcare services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risks" (World Health Organisation Patient Safety Guide, 2019).

Healthcare Improvement Scotland National Framework for Adverse Events describes a six-stage process of adverse event management:

1. Risk assessment and prevention
2. Identification and immediate actions following an adverse event, including consideration of duty of candour
3. Initial reporting and notification
4. Assessment and categorisation, including consideration of duty of candour
5. Review and analysis
6. Improvement planning and monitoring

In NHSGGC, clinical incident reports are recorded through an electronic system (Datix). There is a tiered approach to incident review with the most robust investigation undertaken for events falling within the definition of Significant Adverse Events (SAE). Each (SAE) review is tracked from the initial report through a managed process to confirmation that any resulting actions are complete.

4.3 Review of Significant Adverse Event policy

The Board maintains a policy on Significant Adverse Events, which sets out robust requirements to identify clinical events offering the greatest opportunity to improve safety.

The Policy on the Management of Significant Adverse Events was reviewed in 2020 and the following changes came into effect on 1st October 2020:

- There has been a change in terminology used from Significant Clinical Incidents (SCIs) to Significant Adverse Events (SAEs).
- The Rapid Alert and Severity 4/5 templates have been amalgamated into a Briefing Note template. Both the rapid alert and severity 4/5 tool provided a description of the event. The decision as to what constitutes a Significant Adverse Event depends on the characteristics of the event, the patient or the clinical service, the potential for learning and other review processes. The prompts on the 4/5 tool can be used to aid decision making regarding whether the investigation should commence before the results are available. Amalgamating the two documents reduced duplication and now provides an audit of the decision alongside a description of the event.
- NHSGGC used James Reason's Accident Causation Model as a way of summarising any errors, system issues, barriers and human and environmental factors that contributed to an SAE. Due to staff feedback this will no longer be required and has been replaced by the updated timeline which will be used to summarise this information. NHSGGC uses root cause analysis as the investigative process. These documents are templates developed to capture contributory factors.
- The SAER toolkit has been updated. NHSGGC developed a toolkit of templates and guidance to aid investigation teams with the process.
- The introduction of a standardised process for feedback from Patients/Families involved in SAERs.

4.4 Significant Adverse Event policy during COVID-19 pandemic

In April 2020 all lead reviewers and commissioners were contacted to determine how to progress the 177 open SAERs during the 1st wave of the COVID-19 pandemic. 169 (95%) of the reviews continued, with extra support made available from Clinical Risk. The remaining 8 SAERs were unable to be concluded due to the pressures on the service area at that time. These were suspended and restarted once service pressures allowed. The patients/ families of the suspended SAERs were notified of the decision in line with the Boards obligations under Duty of Candour legislation.

4.5 Significant Adverse Event Review (SAER)

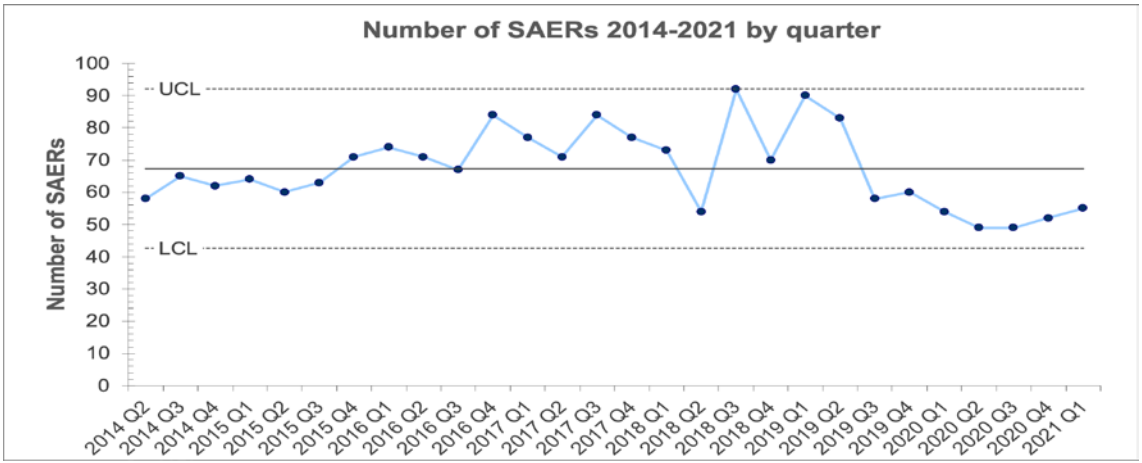
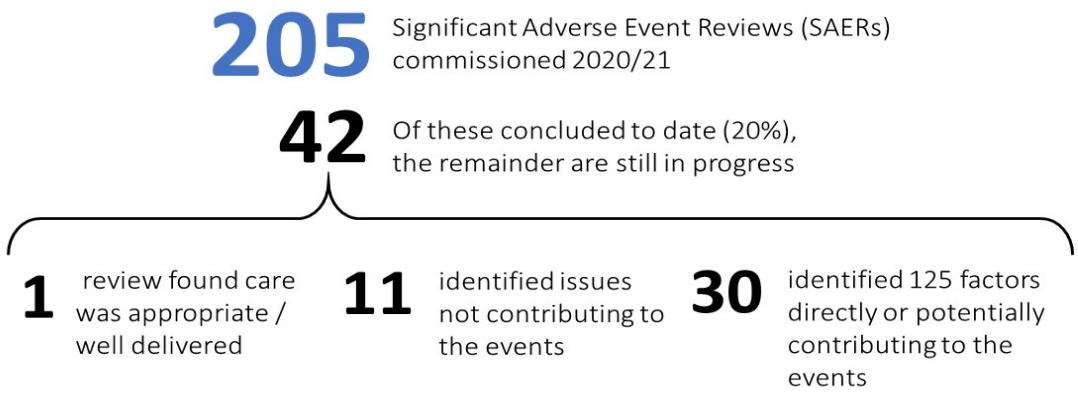


Figure 4.1 – Number of Significant Adverse Event Reviews per quarter from 2014 to 2021

Figure 4.1 shows the number of SAERs from April 2014 to March 2021. There were 205 clinical incidents that triggered SAER between April 2020 and March 2021. This is a decrease of 35 from the previous year.

4.6 Contributory factors and thematic analysis from SAERs

The Clinical Risk team continue to collate contributory factors and themes from closed SAERs across the Board. The following graphic summarises the progress of SAERs to date.



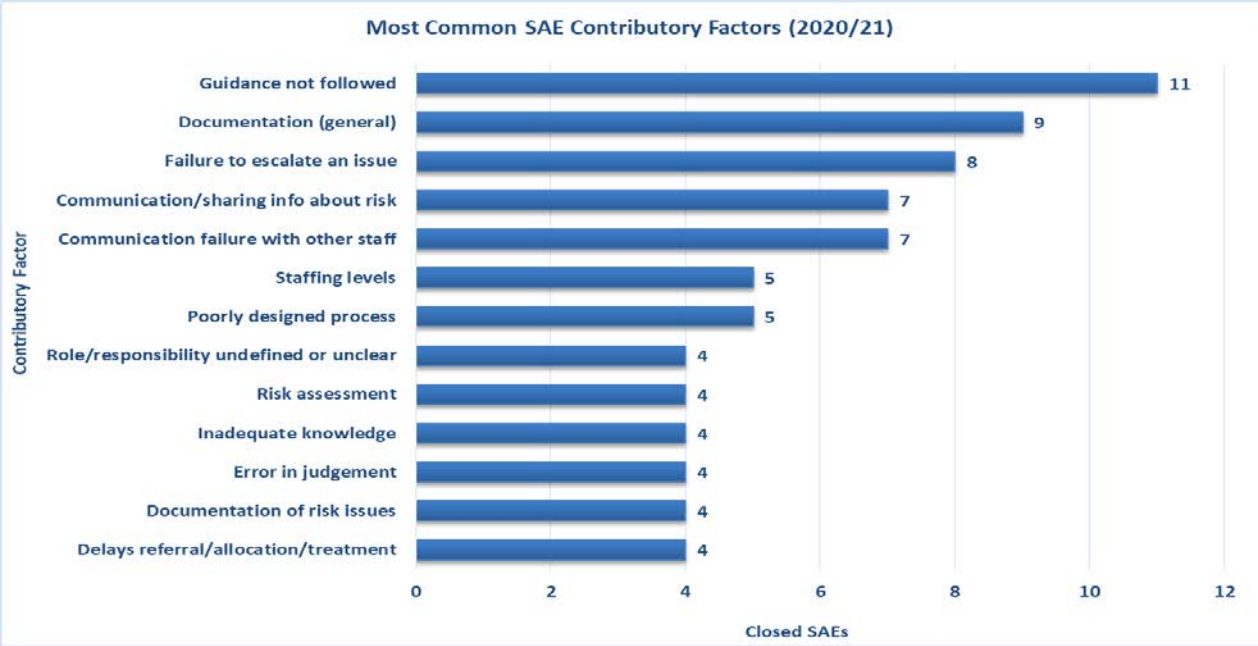


Figure 4.2 – Most common SAE Contributory Factors 2020-21

Figure 4.2 shows the most common direct and indirect factors identified from the 2020/21 SAE reviews which have since closed.

Of the 2020/21 reviews which have concluded the most frequently identified issues relate to guidance not being followed (26%), general documentation issues (21%) and failure to escalate issues (19%). There has been a reduction in the number of SAERS where communication failure with other staff is involved; however it is recognised that a number of events remain under review.

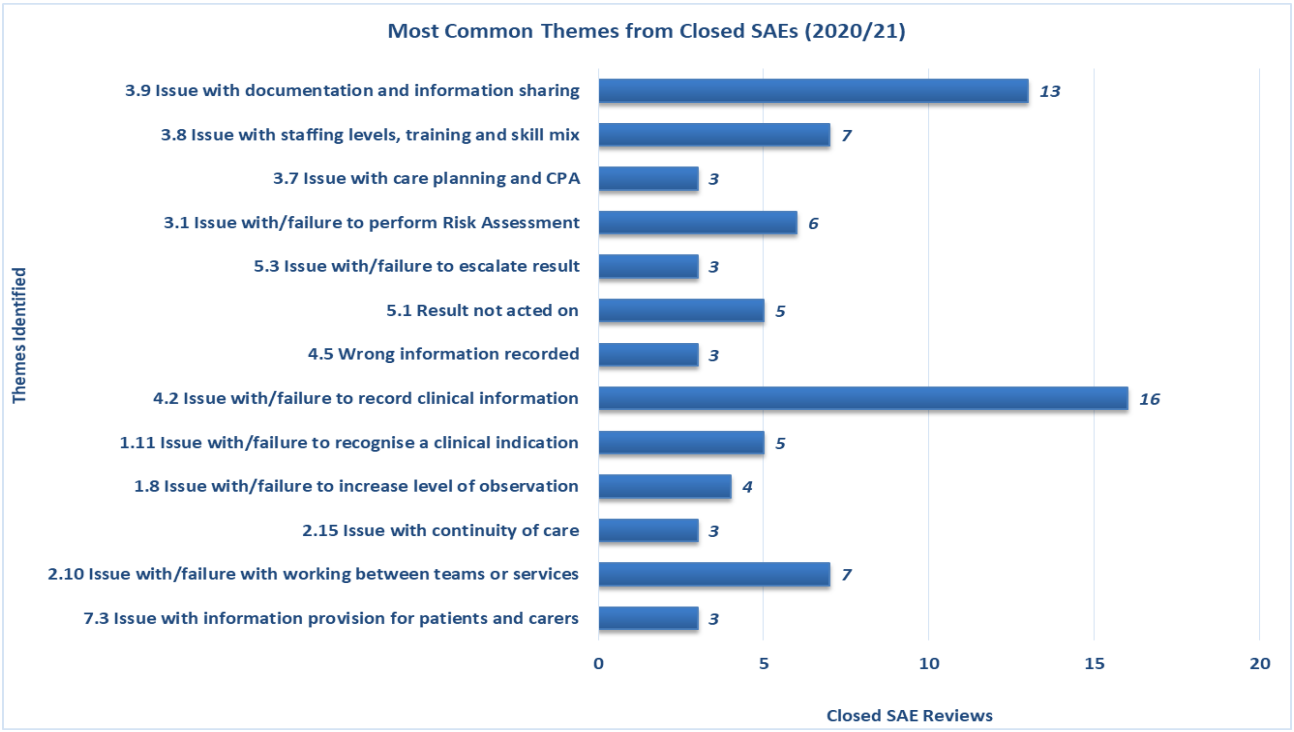
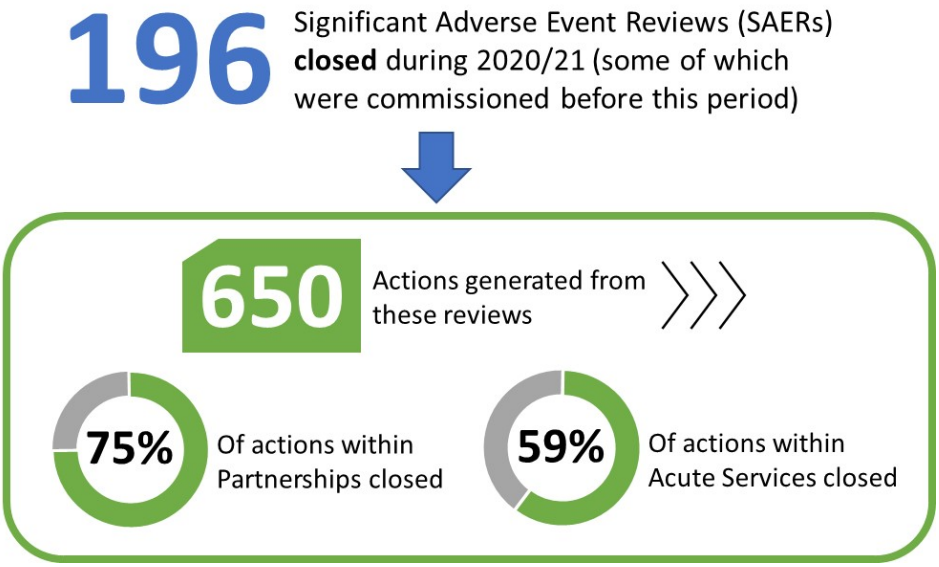


Figure 4.3 – Most common themes from closed SAEs 2021-21

In Figure 4.3, the most frequently identified themes from 2020/21 concluded reviews relate to documentation with issue/failure to record clinical information (20%) being the most common, and issues with documentation and information sharing (16%) being the next common.

4.7 Recommendations from SAERs



A selection of completed actions from key recommendations from these SAERs are;

- A patient was transferred to a medical ward, however it was unclear what care including medication the patient was given in the Emergency Department (ED) as the ED card was missing from patient notes which resulted in an adverse event. As a result of this incident a process was implemented where the ED card is photocopied and accompanies the patient when they are transferred to a ward. This ED card is now included as part of the ward documentation audits. Since this process was implemented in this ED, there have been no reports of any missing ED cards. This audit is done weekly in the ward as part of a Fatal Accident Inquiry recommendation.
- Patient A's results were uploaded to Patient B's file which resulted in inappropriate treatment for both patients. A sticker has been created for Biomedical Scientists (BMS) to sign to confirm patient demographics have been checked. This sticker will be attached to all blood positive blood culture forms to prompt the BMS to check patient details. Due to this change in process, no further errors have occurred.
- A shift handover between Registrars resulted in confusion about the reason for a patient's admission. This resulted in a high potassium and sodium reading from a patient's blood results which were not noted until several days after admission and the patient being moved to several wards. The registrars developed a NEWBIES communication system for handovers.

- As a result of a delay in reviewing a patient, handover documentation has been reviewed to ensure handovers between nursing staff and Scottish Prison Staff (SPS) contain all relevant information. This includes processes relating to the safety brief/ formal handovers at the end of shifts. This has resulted in all three prisons within the NHSGGC board area using the same handover document. An escalation policy has also been implemented which details the communication structure from healthcare charge nurses to nurse team leaders and operational managers.

4.8 Duty of Candour

The statutory duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm). The Statutory Duty of Candour (DoC) legislation became active from the 1st April 2018. The statutory organisational duty of candour has been developed to be in close alignment with the requirements of the professional duties of candour.

Professional Duty of Candour means that every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- apologies to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)

- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short- and long-term effects of what has happened.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.

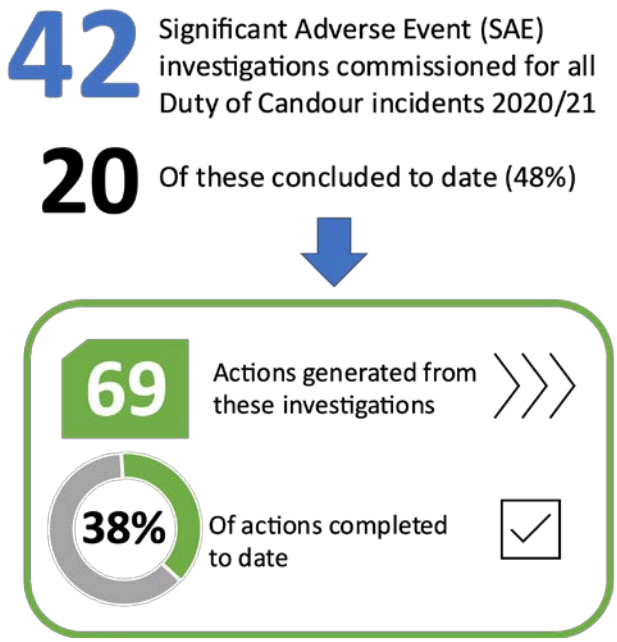
The legislation requires that NHSGGC must also publish a Duty of Candour annual report.

Between 1 April 2020 and 31 March 2021 there were 42 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. Table 4.1 summarises the outcome of the duty of candour incidents that occurred.

Table 4.1 – Outcomes of incidents where the Duty of Candour applied 2020-21

Outcome of unexpected or unintended incident	Number of times this happened
A person died	12
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	26
The structure of a person's body changed	1
A person's life expectancy shortened	2
A person's sensory, motor or intellectual function was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needed treatment in order to prevent other injuries as listed above	1
Total	**42**

This summarises the progress of SAE investigations for Duty of Candour incidents to date.



Apologies were offered to all 20 patients either face-to-face/telephone or by letter and/or accompanying SAE information leaflet. In one case the patient was given an immediate apology but on the advice of their Psychiatry Consultant it was agreed not to ask if they wished to contribute to the review however by the conclusion of the review the patient was offered a copy of the report. In the remaining 19 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.

4.9 Datix

Datix is a web-based system widely used across NHSGGC to record adverse events, complaints and legal claims. The system ensures the Board are compliant with relevant legislation and satisfies our legal obligation to ensure the safety of our staff.

Contract Renewal and Procurement
The support and maintenance contract with Datix has been renewed until May 2022. A soft market search was conducted in 2020. Based on the 21 supplier responses a full requirements specification and Outline Business Case has been developed for a replacement Integrated Incident, Risk Management and Patient Safety System.

NHS Louisa Jordan (NHSLJ)
To support the reporting of adverse events in the temporary NHS Louisa Jordan hospital the support and maintenance contract was expanded to allow the team to configure the NHSLJ and roll out access to the teams working on site.

Whistleblowing
To support the delivery of the new National Whistleblowing Standards and Process (which was launched on 1 April 2021), a new PALS form was developed and implemented across

NHSGGC. The form enables users to ensure all key information for every whistleblowing cases is appropriately recorded. Using the information from the form, reports can be generated on a quarterly and annual basis on the key performance indicators, which is a requirement of the Standards. Due to the sensitive nature, only a small cohort of essential staff have access to the form.

4.10 Next Steps

Safe care: Next steps 2021/22

- Review of the NHSGGC Duty of Candour Policy (approval stage)
- Review of the NHSGGC Consent Policy (approval stage)
- Acute Division-wide SAERs Quality Assurance process in development
- Procurement for a replacement Integrated Incident, Risk Management and Patient Safety System. – Subject to Outline Business Case approval, a standard procurement process will be undertaken supported by IT Procurement colleagues at National Services Scotland.

5 Effective Care

5.1 Summary of Key Achievements

Effective care: Key Achievements 2020/21

- Eight cohorts of the Scottish Improvement Foundation Skills (SIFS) virtual quality improvement training delivered.
- Five successful NHSGGC candidates for the national Scottish Quality & Safety Fellowship Programme.
- Development of an evaluation toolkit to support CGSU evaluation strategy (in draft and testing).
- Support and evaluation expertise provided for Evaluation of the Person-Centred Virtual Visiting service.

5.2 Quality Improvement Programmes

Quality Improvement programmes aim to improve the safety and reliability of care within the healthcare setting. These programmes of work align to board and national priority areas which are detailed below.

In March 2020 in response to COVID-19, the decision was taken nationally and locally to temporarily suspend the planned work of the following programmes. Engagement with Acute, Mental Health and Primary Care Divisional Clinical Governance chairs is underway to identify priorities for quality improvement programmes following suspension.

5.2.1 Deteriorating Patient

The programme remains suspended due to service pressures from COVID-19. Discussions are progressing within the Acute Clinical Governance Forum to agree a new programme infrastructure and steering group. This will set overall programme objectives, giving consideration to the new Healthcare Improvement Scotland (HIS) Acute Adult collaborative focusing on Deteriorating Patient. The planning and consultation process is due to start in spring 2021, with an expected launch in autumn 2021.

5.2.2 Maternity & Children Quality Improvement Collaborative (MCQIC)

This programme resumed in August 2020, with monthly data submissions to the national team submitted in December 2020. Each programme is measuring and reporting on their key safety priority areas. Regular monthly reports on progress are reviewed by the Chief Midwife/Chief Nurse and are tabled at the local Quality Improvement Groups.

5.2.3 Mental Health Quality Improvement Programme

This programme remains suspended. Discussions are progressing with the programme and service leads to plan a revised programme. This will incorporate the main safety priorities from the national team around Least Restrictive Practice as well as refreshing the Culture and Leadership work stream. The expectation is for the new programme to start in Summer 2021.

5.2.4 Primary Care Quality Improvement Programme

Discussions between CGSU and key individuals in relation to the development of a new Quality Improvement programme in Primary Care were put on hold due to COVID-19. Plans are in place to restart this planning process, linking the programme to the overarching work of the Primary Care Programme Board.

5.3 Evaluation, Learning and Networking

Learning, Evaluation and Networking as a broad theme has become a key work area for the Clinical Governance Support Unit, with specific objectives to develop an evaluation strategy for the board and to support evaluation projects. An accompanying toolkit to facilitate evaluation is in draft and testing, most recently in supporting the evaluation of the Person Centred Virtual Visiting Service.

Another key work area is the development of the networks and structures to share the learning from evaluation to aid the spread of improvement, however much of this work has had to be put on hold over the last year due to COVID-19.

The Clinical Quality Improvement Network (CQIN) was established in 2017, which was developed to

- support and enhance Quality Improvement practice across NHSGGC
- support the development of QI capability
- create opportunities for collaborative interaction
- promote successes and share learning

The Network commenced a review process in January 2020 to re-focus the purpose and reach of the network. These activities were put on hold due to COVID-19 in March 2020 and will be resumed in Autumn 2021.

5.4 Quality Improvement Capability

NHSGGC supports staff to develop the necessary knowledge and skills to be able to use quality improvement methods and approaches effectively in order to drive improvements.

The approach taken within NHSGGC is to provide a range of opportunities for developing quality improvement capability that can meet the need for the diverse range of skills and expertise required for support.

One of the Clinical Governance Support Unit's objectives is to support the development of quality improvement (QI) capability building within NHSGGC through the delivery of quality improvement educational programmes, as well as providing ongoing coaching support to delegates as they undertake their own projects within their own working environments.

Using a combination of locally delivered training and national quality improvement programmes, the current numbers for NHSGGC staff is shown in Table 5.1

Table 5.1 – NHSGGC staff trained through QI programmes

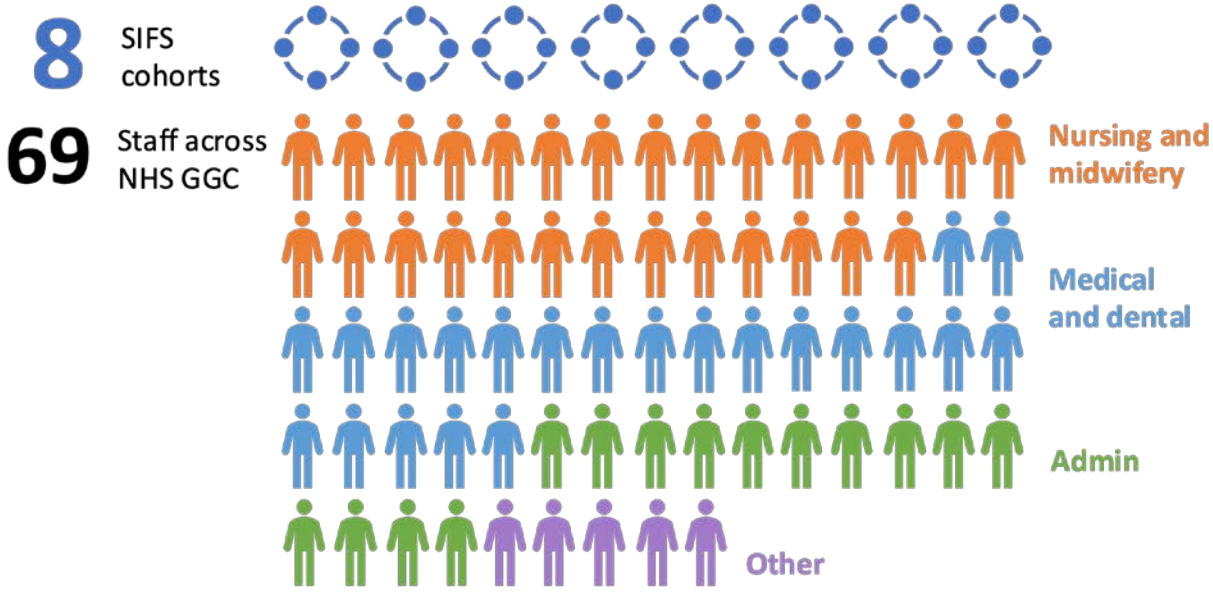
Type of training	Number of current staff
Scottish Quality and Safety Fellowship	30
Scottish Improvement Leaders (ScIL)	55
Improvement Advisors (IA)	4
Scottish Coaching & Leadership for Improvement (SCLIP)	89

5.4.1 NHSGGC Quality Improvement Training

Scottish Improvement Foundation Skills (SIFS) Programme

The CGSU currently deliver structured QI training through the Scottish Improvement Foundation Skills (SIFS) programme. This was developed by NHS Education Scotland and endorsed for local delivery by NHS Boards. The programme is delivered virtually through Microsoft Teams to cohorts of 10-15 staff. Delegates are supported to develop the skills, knowledge, and confidence to participate as members of QI teams and contribute to testing, measuring and reporting on changes made in their local clinical settings.

By the end of December 2020 eight cohorts totalling 69 staff across NHSGGC had completed the SIFS programme.



5.4.2 Scottish Coaching and Leadership 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 last locally delivered cohort of SCLIP was completed in March 2020 and all further plans were put on hold due to COVID-19. A planning process for a new cohort of SCLIP is underway with the next cohort due to start in October 2021.

5.4.3 Return of Investment

A Return of Investment process is being implemented for all staff completing both the SIFS programme and SCLIP to formally evaluate these programmes. This process will be using Kirkpatrick's 4 level model:

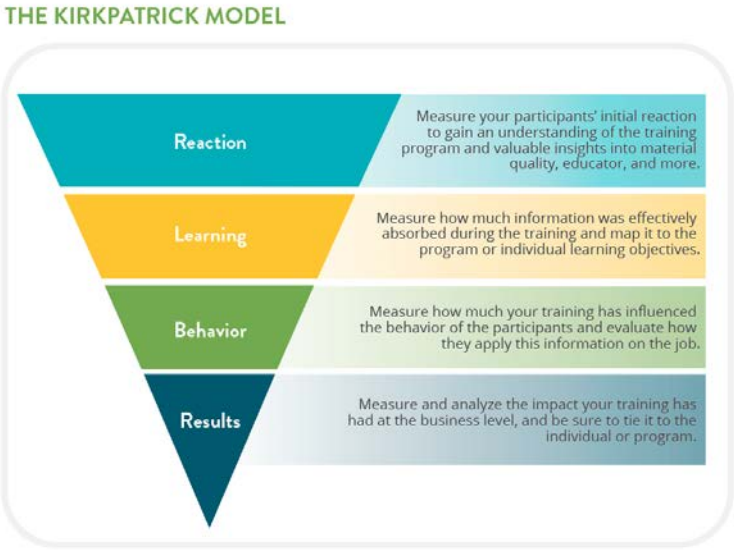


Figure 5.1 – Kirkpatrick's 4-level model used for return of investment process

This will support the analysis and evaluation of the results of these training programmes and whether the learning gained from attending the training has been put into practice. The Reaction and Learning surveys are already in use for the SIFS programme and the follow-up Behaviour surveys are due to be sent out in July 2021. These will be continued on an ongoing basis with results reported annually.

5.4.4 National Quality Improvement Training

NHS Education Scotland (NES) recruited for a new national cohort of the Scottish Quality and Safety Fellowship. From NHSGGC, there were 13 applications submitted from Medical staff, Nursing & Midwifery, Pharmacy and AHPs. Following the shortlisting and interview phase, there were five successful applicants for this programme.

Recruitment for the next two national cohorts of the Scottish Coaching and Leading for Improvement Programme (SCLIP) concluded in June 2021. This programme is targeted at managers and leaders within Nursing and Midwifery, AHPs and Health Scientists.

5.5 Spotlight on Innovation and Improvement

The following is a summary of some examples of quality improvement projects and innovations which were completed during the course of 2020-2021.

Spotlight on Innovation and Improvement

NEWS2

A new version of the National Early Warning Scoring (NEWS) system was developed and this had to be rolled out across nine NHSGGC acute hospital sites, six HSCPs and seven mental health sites. This work was undertaken by short life working group, comprising of ward-based staff, medics, practice development nurses, clinical nurse specialists and representatives from HSCPs and mental health partnerships. The group developed a NEWS2 clinical guideline which provided guidance on how to complete the chart, use it to recognise patient deterioration and how to escalate those patients to an appropriate clinical decision maker.

When it came to rolling out NEWS2, the corporate Practice Development team utilised QI methodology throughout the project, in particular in the development and testing of the prototype NEWS2 chart. This involved multiple Plan Do Study Act (PDSA) cycles undertaken to co-design the new NEWS2 chart, starting small on four test sites (including 2 wards from neurological sciences who had no prior experience with NEWS). The team used data and run charts to monitor the effectiveness of the tests of change, ongoing feedback from the testing teams, helping to steer further iterative changes.

NEWS2 was successfully rolled out across NHSGGC between 1st September 2020 and 2nd November 2020, by the corporate Practice Development team.

Feedback from the clinical front line and observation of clinical practice is that the introduction of NEWS2 has resulted in:

- ✓ Improved frequency and accuracy of NEWS scoring,
- ✓ Improved quality of chart completion overall,
- ✓ Improved design of the chart from the previous version,
- ✓ Improved patient safety (recognition) when a patient's condition has deteriorated and,
- ✓ Standardised system adopted by all acute adult, HSCP and Mental Health service.

MYPSYCH APP

The MyPsych App was created by NHSGGC in collaboration with colleagues throughout NHS Scotland with the purpose of providing convenient access to Mental Health information toolkits. The MyPsych Team has developed the MyPsych App into a resource for all mental health practitioners, medical students and doctors undertaking their foundation and postgraduate training in psychiatry.

The MyPsych prescribing companion contains important information on medicines in a user-friendly format as well as an A-Z list of all guidance. In addition, a MyPsych research toolkit has been developed which aims to increase recruitment to active clinical studies.

A summary of key information for current and forthcoming studies including eligibility criteria is included as well as information to support NHSGGC staff in becoming more research active including links to training, funding and guidance.

In response to COVID-19, the MyPsych NHSGGC toolkit was developed with the purpose of gathering and disseminating all up-to-date information as this was being generated and made available. Since launch the app has had 15,000 users and 35,000 page views. Survey results reported that over 85% of responders felt the app would improve safe and timely practice.

DISTRICT NURSING IN RENFREWSHIRE

A complaint was made in May 2020 from a family raising issues related to a delay in receipt of palliative care medications highlighting the distress that this caused to both the patient and the family. As a result of the investigation into the complaint, the team undertook the following service improvement recommendations to ensure this situation would not occur again.

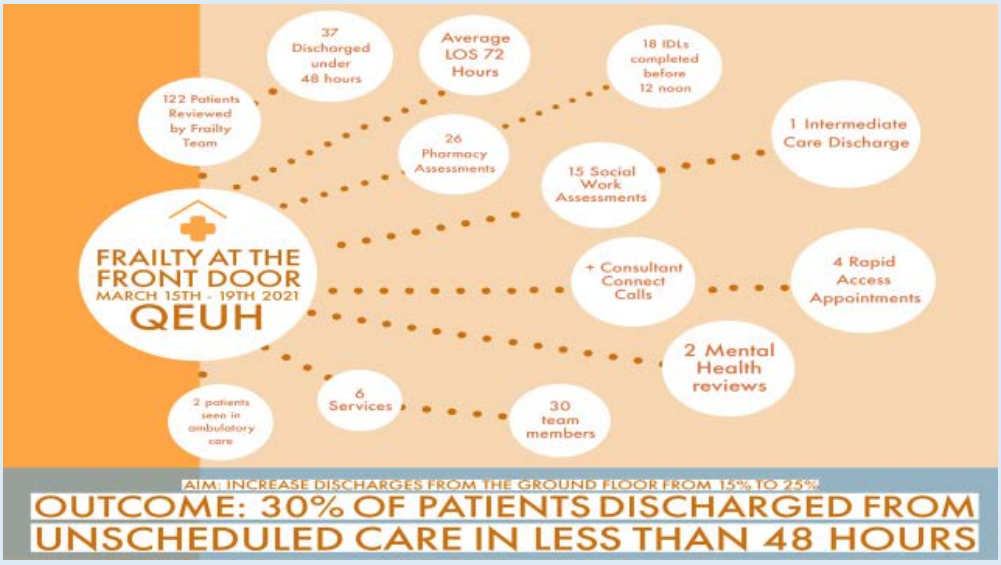
- ✓ The patient and family story and investigation findings shared with the District Nursing teams so they were all aware of the situation and the service wide learning.
- ✓ Ensure all staff have an awareness and know how to access OOH pharmacy services for palliative care medication – Palliative care development session completed September 2020 led by lead palliative care pharmacist.
- ✓ Development of a standard operating procedure for palliative care in the community to support staff with their self-assessment of competency and direct training needs.

FRAILTY AT THE FRONT DOOR

The Queen Elizabeth University Hospital (QEUH) Frailty Team had success in improving the identification of frailty and reducing length of stay for patients when it was established in 2016 and the team wanted to build on this approach by testing an enhanced team with a home is best ethos as well as testing new pathways with closer links with the Emergency Department.

In March 2021, the Frailty Team undertook a project which had the aim of increasing the number of discharges from unscheduled care in frail older adults from 15% to 25%. The project also ensured all individuals over 75 years and all those over 65 from a nursing home received a frailty assessment and initiation of comprehensive geriatric assessment (CGA).

Results from the test showed that the team exceeded their aim and managed to achieve 30% of patients being discharged from unscheduled care in less than 48 hours.



The team have kept this model in place and are continuing to work at the QEUH with close access to social work and psychiatry.

IMPROVING CARE THROUGH COMPREHENSIVE GERIATRIC ASSESSMENT

Project Lead: Margo Pratt, Clinical Improvement Coordinator, CGSU

Older People Services at Inverclyde Royal Hospital aimed to improve unplanned care by ensuring that Comprehensive Geriatric Assessment (CGA) is initiated within 24 hours of presentation for 90% of Frail People age 75 years and older presenting at Inverclyde Royal Hospital by June 2020.

Evidence shows that reliable identification, timely CGA and coordination of activities for older people with frailty who attend hospital for unscheduled care improves their outcomes and experiences, whilst also reducing avoidable admission or length of stay in hospital where admission is required.

The incorporation of the dataset within daily activities helped to locate patients who required CGA more quickly, with less trips around the hospital. This improvement can be seen in Chart 1 which shows that since 05/01/2020, all points (excluding 02/02/2020) were above the mean.

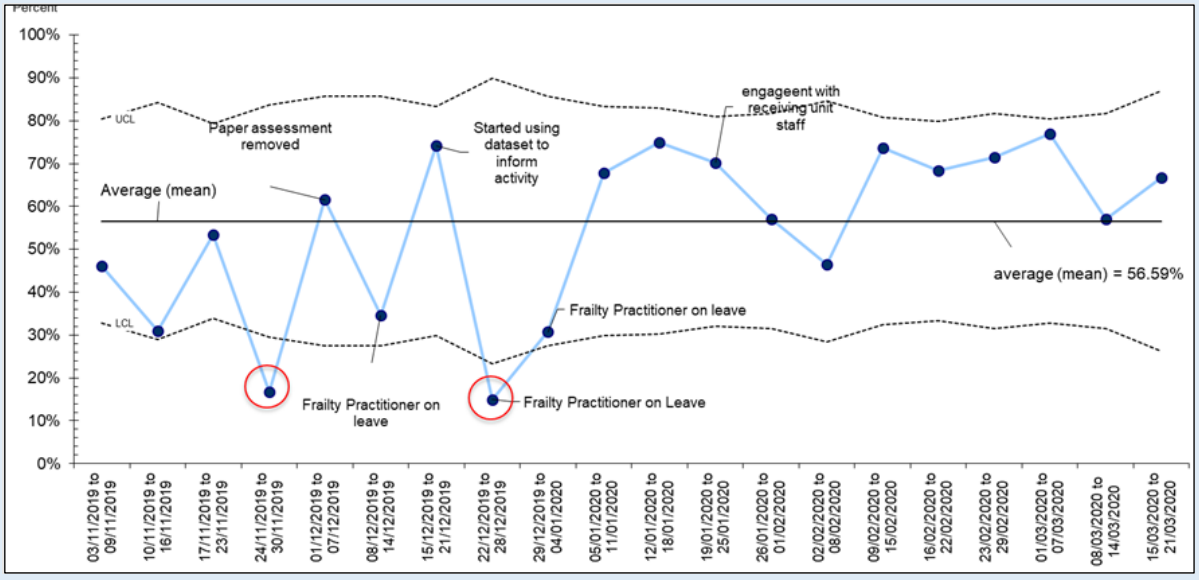


Chart 1 – Percentage of frail people over 75 who had a CGA initiated within 24 hours of admission to Medical Acute Ward

Improvements can also be seen in Chart 2 below where the weekly average time to CGA is below the mean of 54 hours for 10 consecutive weeks.

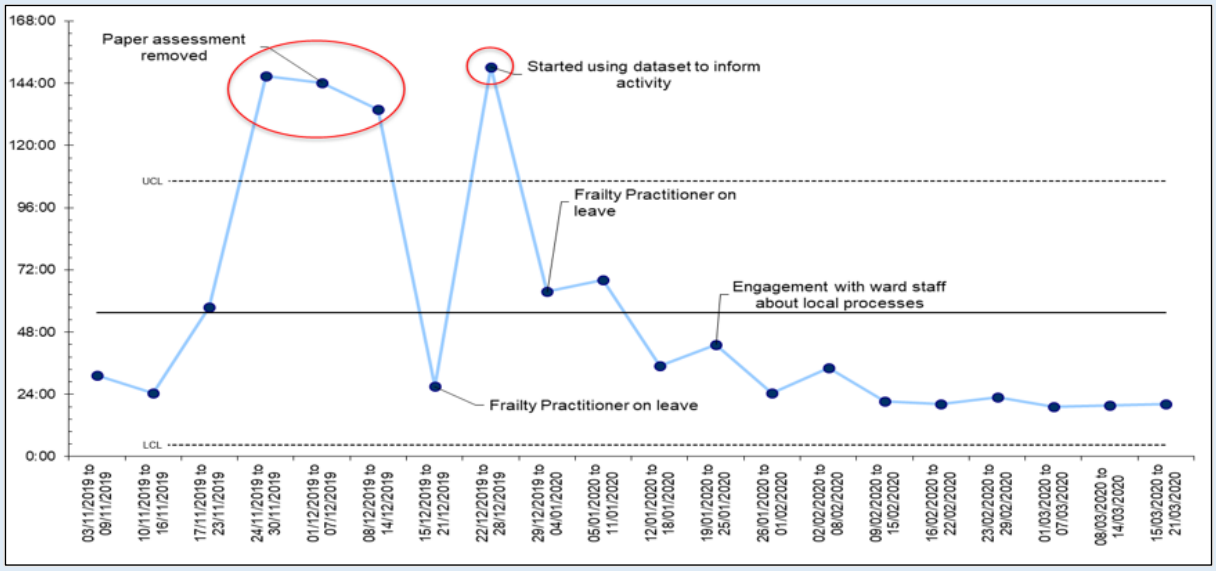


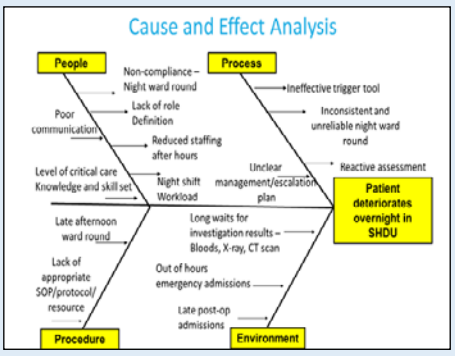
Chart 2 – Average number of hours to initiate CGA

THE ONES TO WATCH

Project Lead: Shona McKie, Staff Nurse

By November 2020, the project aimed to reduce the number of overnight deteriorating patient referrals from the Surgical High Dependency Unit (SHDU) to the Intensive Care Unit (ICU) at Glasgow Royal Infirmary by 25%.

This was a priority for the ward as over a period of eight months they had three times as many night shift deteriorating patient referrals to the Intensive Care Unit as day shift referrals. The team developed a Fishbone diagram to help them understand the barriers and the issues regarding deteriorating patients in the SHDU.



The team came up with several change ideas to help them improve their processes including; developing a Night Shift Handover Standard Operating Procedure, the creation of 'Watchers' (a tool to highlight patients at risk of clinical deterioration), Watchers being discussed at safety briefs and are seen first on the night shift ward round, and a senior medical led night shift ward round.

The charts show signs of improvement with longer days between night shift referrals from SHDU to ICU (increase from 17 to over 160 mean number of days between referrals).

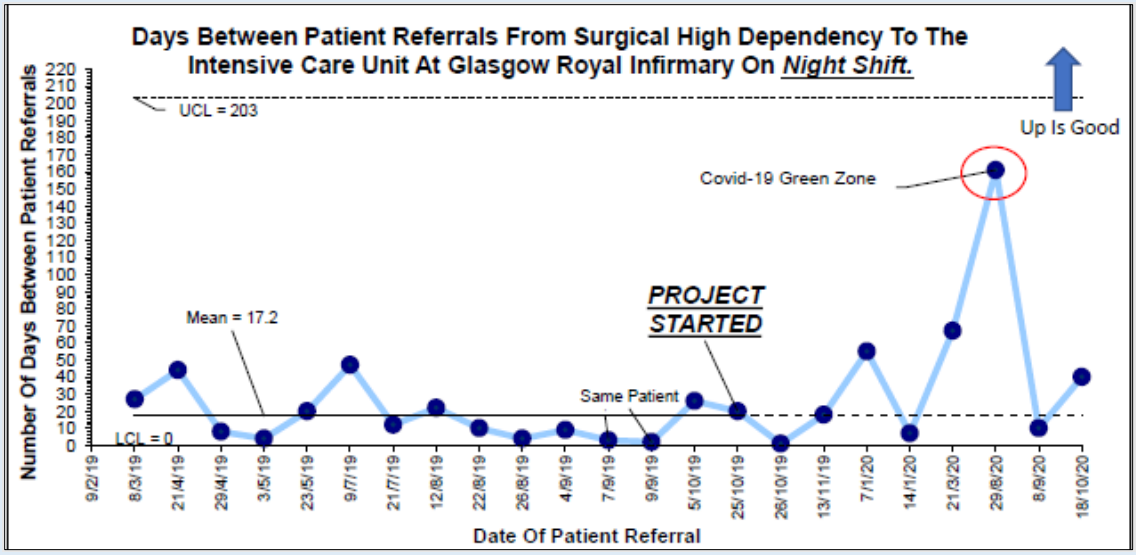


Chart 3 – Days between night shift referrals from SHDU to ICU over time

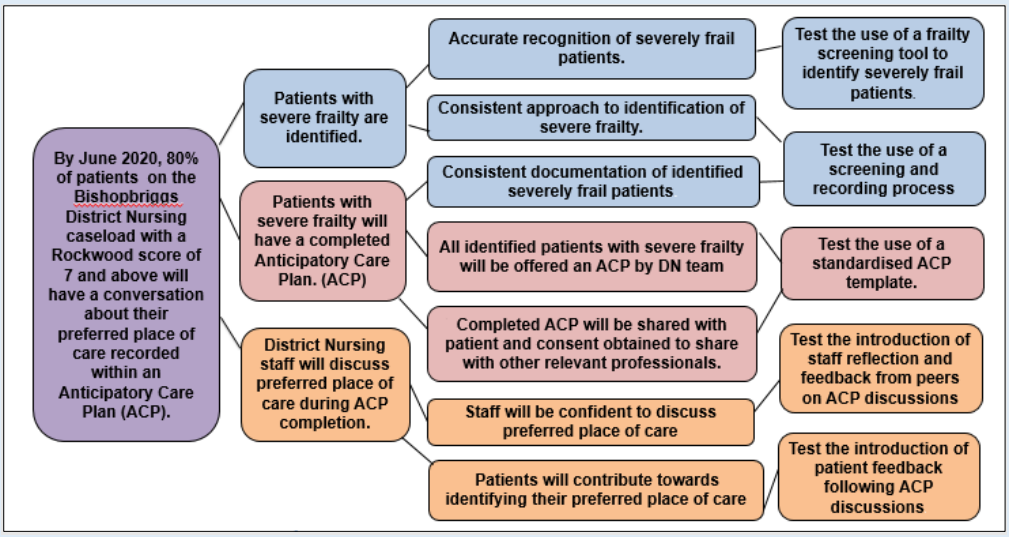
- ✓ The project met its aim of reducing the number of night shift deteriorating patient referrals from SHDU to ICU
- ✓ There has been feedback from ward staff and managers that this improvement work has not only improved recognition and response to clinical deterioration, but has also increased situational awareness, teamwork and communication.

IMPROVING PREFERRED PLACE OF CARE CONVERSATIONS WITH SEVERELY FRAIL PATIENTS

Project Lead: Kathleen Halpin, Senior Nurse CGSU

The Bishopbriggs District Nursing Team in East Dunbartonshire HSCP aimed to have a conversation about preferred place of care with 80% of eligible patients (with a Rockwood score of 7 and above) on their caseload and record this within an Anticipatory Care Plan (ACP) by June 2020.

Ensuring these conversations have been recorded will allow all key Health Care Professionals to easily access this information and will support discussions about appropriate treatment options whilst ensuring that the patient's wishes have been met. This should reduce unnecessary admissions to hospital and inappropriate interventions. The team tested the Rockwood Frailty tool as a means to identifying the most eligible patients for this conversation. They also tested a new screening and recording tool. The team developed a driver diagram which summarises their theory of change for the project.



The below chart shows the effect these changes had on the percentage of eligible patients who had a completed Anticipatory Care Plan (ACP).

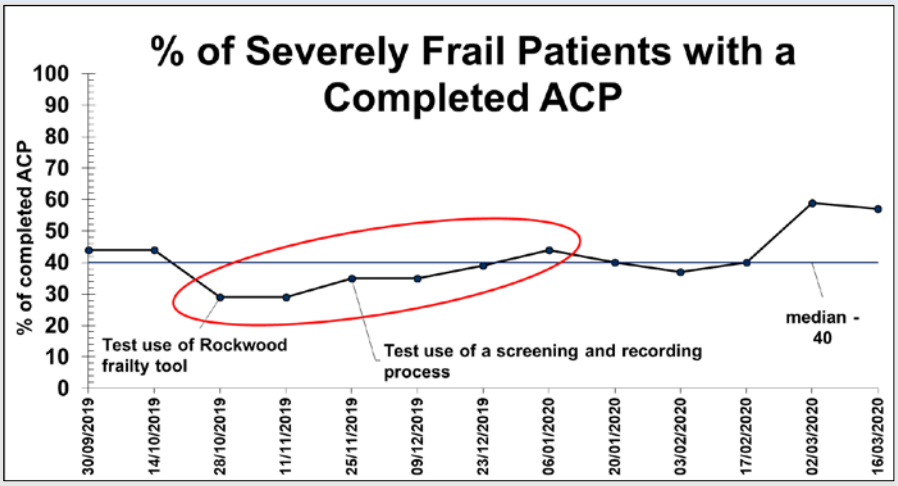


Chart 4 – Percentage of Severely Frail Patients with a Completed ACP in period before pandemic

Due to COVID-19, the improvement project and data collection stopped until the first lockdown ended, however, the project team continued to complete a frailty score for all patients admitted to their caseloads. Data was collected (see Chart 5 below) after the first wave between August and December 2020 which showed there was an improvement of completed ACP's despite the pressures on staff caused by COVID-19. The pandemic has highlighted the importance of ACP completion for severely frail patients and discussing preferred place of care.

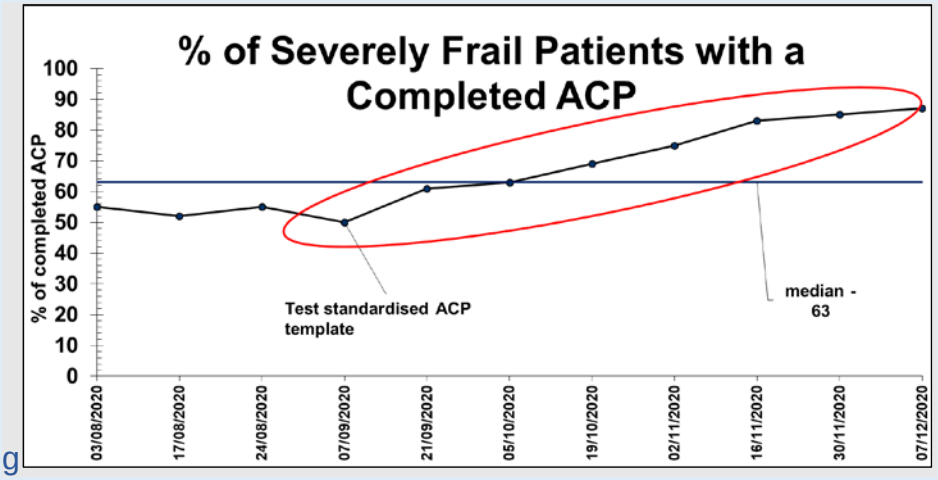


Chart 5 – Percentage of Severely Frail Patients with a Completed ACP after first wave

The tools and process have now been standardised and implemented across all District Nursing (DN) teams in East Dunbartonshire Health & Social Care Partnership (HSCP). This has increased the number of ACPs completed for severely frail patients on DN caseloads and has enabled patients to have a timely conversation about future wishes of treatment. ACPs are now uploaded on to clinical portal which is accessed by Out-Of-Hours service, primary care and acute services. This work has been shared with other Multi-Disciplinary Teams within East Dunbartonshire HSCP and also across Care Homes.

Some patient feedback as a result of this project includes:

"This (ACP) gives me peace of mind knowing I won't need to go into hospital and leave my wife behind."

"Thank you for taking time to talk to me and let me know that it's ok to stay at home and not go back into hospital. I didn't know I had a choice."

REDUCING FALLS IN AN ACUTE MEDICAL WARD

Project Lead: Jane Howie, Practice Development Nurse

This project aimed to reduce the mean number of reported falls in a month in the acute medical ward at the Inverclyde Royal Hospital (IRH) by 35% from 9 to 6 by June 2020.

The Acute Medical ward was selected as baseline data highlighted that this ward had a 45% above average in the sector. The project team carried out an audit of the Falls Risk Assessment and used the results to create a Pareto Chart (see Chart 6). This process enabled them to identify areas to prioritise their improvement activity.

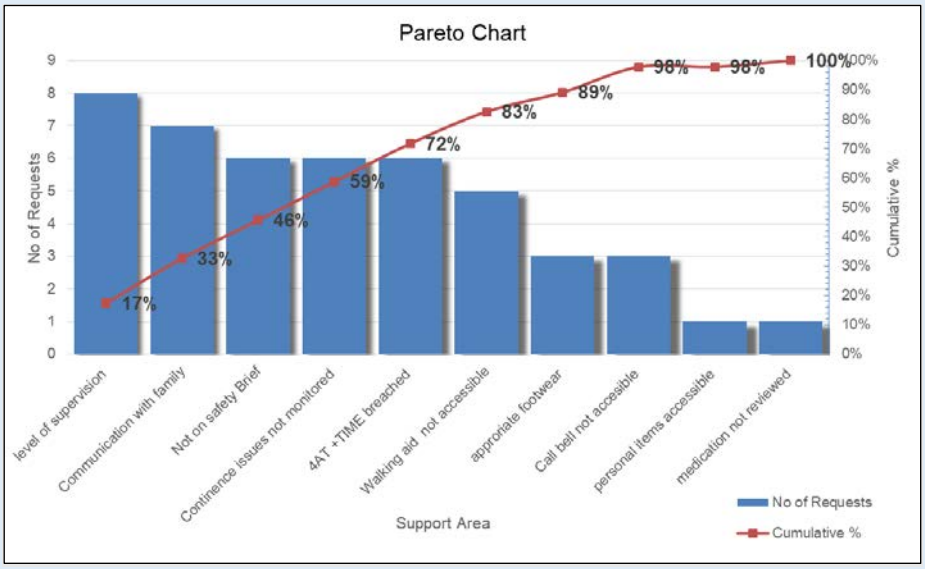
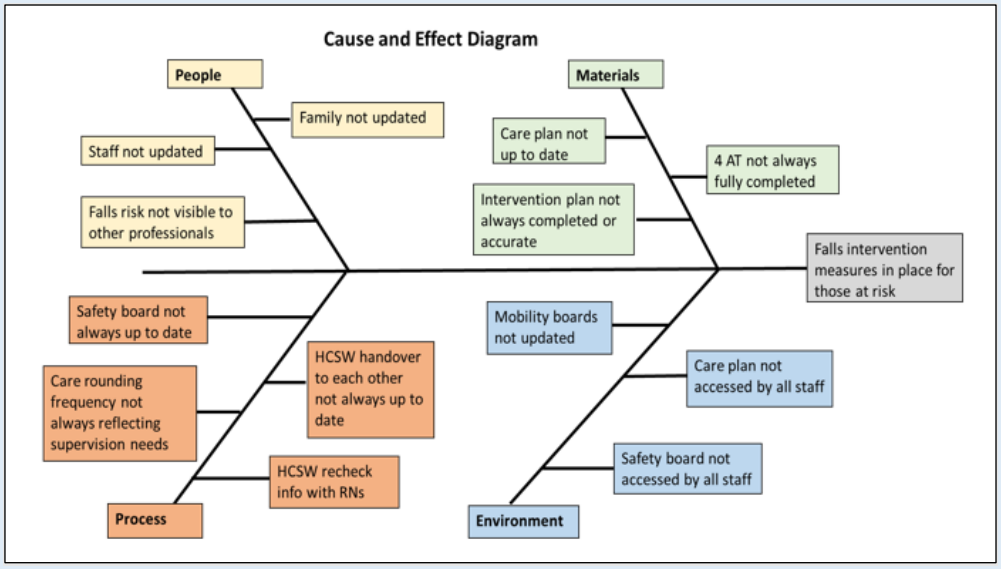


Chart 6 – Reasons for Falls in IRH Acute Medical Ward

The staff created a Fishbone Diagram to identify the barriers and causes of the increased rate of falls on the ward.



The first change that tested in the ward was the revision of the Safety Board. The C Chart below shows that this change had a positive effect in reducing the number of falls being recorded for 6 months between October 2019 and June 2020 with these months all being below the median of 9 falls per month. The chart also highlights the increase in the number of recorded falls at the same time the project was paused due to COVID-19.

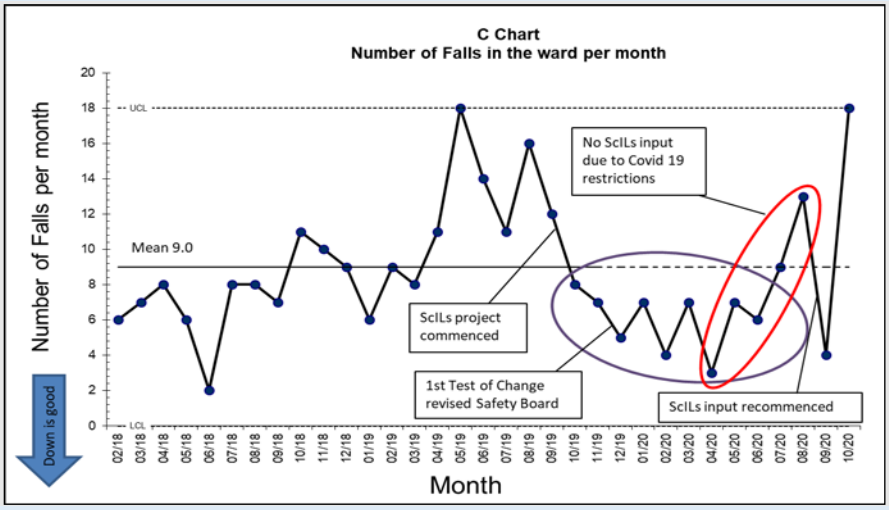


Chart 7 – Statistical Process Control (SPC) chart of number of falls by month

The project aim was not achieved however, the project lead acknowledges that engaging the ward team in applying the model for improvement showed some promising results. Sharing the SPC charts with the team highlighted whether their change ideas had a positive impact on the number of recorded falls and whether these needed to be modified or adapted.

5.6 Next Steps

Effective care: Next steps 2021/22

- Remobilise and refresh the Quality Improvement Programmes for Deteriorating Patient , Mental Health and Primary Care.
- In April 2021, six new SIFS cohorts totalling 112 staff commenced. Three of these cohorts support the priorities of the NHSGGC Quality Strategy focusing on Infection Prevention and Control.
- Plan and deliver new local NHSGGC cohort of the Scottish Coaching and Leading for Improvement Programme (SCLIP).
- Continued testing and development of the evaluation toolkit within NHSGGC.

6 Assurance

6.1 Summary of Key Achievements

Assurance: Key Achievements 2020/21

- A suite of dashboards has been designed and built for testing, which includes Hospital Standardised Mortality Ratio (HSMR), Sepsis and Venous Thromboembolism (VTE).
- Implementation of a data dashboard to accompany the cardiac arrest monthly reports, which has been well received.
- A new process was introduced for the approval and upload of new clinical guidance relating to COVID-19.
- Processes to maintain the NHSGGC Clinical Guideline Directory continued to work well, with 745 guidelines accessible on the directory.
- New process for the review and reporting of Scottish National Audit Programme (SNAP) publications was introduced in 2020, and was commended by SNAP.

6.2 Clinical Informatics

The Clinical Informatics work programme aims to improve access to meaningful data and present the data in a much more user friendly and interactive way. Data dashboards have been explored extensively and a suite of data dashboards developed in Excel for testing. The dashboards allow benchmarking and create conditions in which data can facilitate decision-making at different levels. They are fully interactive and allow the user to review data over time as well as specific areas in time. These are built to allow monthly, quarterly and yearly data reviews from 2018 onwards.

The clinical informatics programme has seen the team involved in various exemplar projects over the past 12 months. We have been involved in the following projects:

- Hospital at Home
- Scottish Trauma Audit Group
- Mental Health
- Falls V Care Assurance & Improvement Resource (CAIR)
- Thrombosis

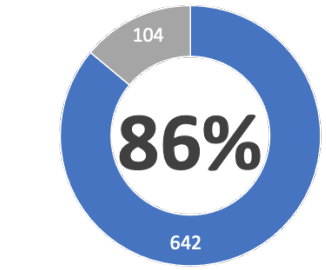
6.3 Clinical Guidelines

Clinical guidelines are systematically developed statements designed to assist clinicians and patient decisions about appropriate health care for specific clinical circumstances. Guidelines should be based on evidence, combined with local knowledge to ensure that they are appropriate for local conditions.

The NHSGGC Clinical Guideline Framework was first published in April 2012. At that time the Board recognised the need for a more robust process for the development, review,

approval and monitoring of clinical guidelines. This framework incorporates both medicine and non-medicine related clinical guidelines.

A central web-based directory of approved clinical guidelines is available to staff in NHSGGC via the intranet, within the NHSGGC Clinical Guideline Directory. This was developed to reduce potential duplication, and to support standardisation and review of clinical guidelines.



OF CLINICAL GUIDELINES REMAINED CURRENT AND VALID AS AT 31ST MARCH 2021

Of the 746 clinical guidelines on the directory, 86% remained current and valid as at 31st March 2021. The Gentamicin dosing calculator remains consistently the most accessed guideline on the directory, the table below highlights the top 10 guidelines from 1st April 2020 –31st March 2021.

Table 6.1 – Annual hits for the top 10 most accessed clinical guidelines 1st April 2020 – 31st March 2021

10	• Heparin dose adjustment renal impairment	1616
9	• COVID-19 a clinicians guide to COVID-19 management, respiratory, GRI	1641
8	• Hypertension management, Heart MCN	1771
7	• Protected antimicrobial monitoring form adult	1823
6	• Empirical antibiotic therapy, infection management, adults	1890
5	• Vitamin B12, treatment of deficiency in adults	2047
4	• Heparin dose adjustment, adult patients with very high or low body weight	2160
3	• Vitamin D prevention and treatment of deficiency in adults	2224
2	• Treatment of IDA in adults	2272
1	• Gentamicin dosing calculator adults	21806

A range of COVID-19 guidance documents were rapidly developed and disseminated for use within NHSGGC during the COVID-19 pandemic, to reflect required changes to clinical practice, pathways or processes. COVID-19 specific guidance documents were approved by the COVID-19 Tactical Groups, for upload to the guideline directory and a designated area within the Right Decision platform, using a fast-track approval process. At the first peak, an average of 56 documents were uploaded per week. Excellent channels of communication

were key to this process and meticulous planning took place every day to ensure there were no delays in the process.

6.4 Clinical Quality Publications

6.4.1 Framework for Clinical Quality Publications (CQPs)

NHSGGC have defined Clinical Quality Publications as a suite of documents which seek to inform and assure clinical practice and processes, such as national standards and guidance, evidence-based guidelines, and identified national audit and benchmarking reports.

The NHSGGC Framework for Addressing Clinical Quality Publications aims to ensure that relevant publications are reviewed within the Board, and any actions considered. The scope of this framework includes:

- National guidance documents - produced by the Scottish Intercollegiate Guidelines Network (SIGN) and the National Institute for Clinical Excellence (NICE)
- National Standards - produced by Healthcare Improvement Scotland (HIS)
- Interventional Procedure Guidance (IPG) – produced by NICE
- Agreed Clinical Quality Publications (national and benchmarking reports containing NHSGGC data) - published via an established list of bodies

The number of publications impact assessed in line with the Framework has decreased slightly since 2019/2020, from 68 to 63 clinical quality publications. The table below details the type of publications identified for 2020-21.

Table 6.2 – Clinical quality publications by type

Type of publication	Number of publications
Publications	23
Cancer publications*	11
National guidelines	4
HIS standards	1
Scottish Health Technology Group publications	6
NICE Interventional Procedure Guidance	18
Good practice guide	0
Total	**63**

** 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 summary position for publications is reported bi-monthly to the divisional level Clinical Governance Forum to confirm service review and next steps, if required.

6.4.2 Red flag process

Following a review of the clinical quality publication, a red flag is applied where NHSGGC is considered to be an outlier in a standard, measure or indicator, >3 standard deviations (SD) from the mean or national average; or where there is agreement that an outlier/ outstanding action is considered a clinical risk, or where it may constitute a risk to the reputation of NHSGGC. A red flag can be triggered through the following processes: through the initial service review of the publication, by notification/ alert to the Board; or by a Clinical Governance Forum where the publication is being considered.

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. The inclusion of a risk rating score provides the appropriate review group with a better understanding of the level of risk, and the priority of any proposed actions.

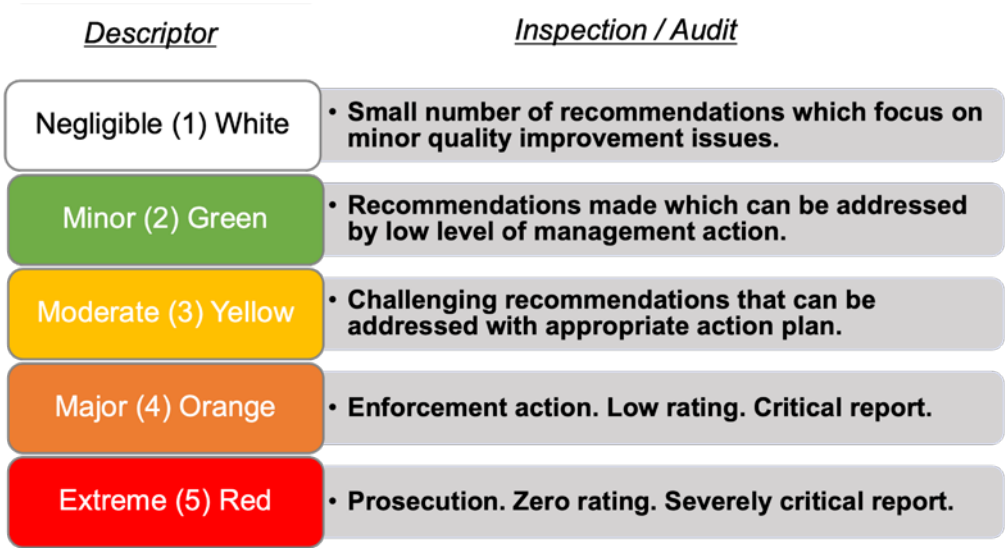


Figure 6.1 – Risk rating scoring key

6.4.3 Scottish National Audit Programme (SNAP)

Public Health Scotland (PHS) publish the Annual National reports for selected audits/ registers. These reports outline the performance of all hospitals in Scotland, who submit data to the audit/ register, in line with agreed national clinical standards or key Performance Indicators. NHSGGC receive an official alert through the Scottish National Audit Programme (SNAP) of any outliers within the national reports and are required to respond in line with the SNAP Governance Policy.

In July 2020 NHSGGC was an outlier in 11 indicators (5 which are 3 or more standard deviations (SD) from the Scottish mean, requiring a full clinical review and investigative report to SNAP; 5 which are 2-3 SD from the Scottish mean, requiring data review; and 1 which requires review/ action). A review of all outliers was completed and submitted to SNAP within the agreed timeline. This required excellent communication and support from the relevant clinical leads.

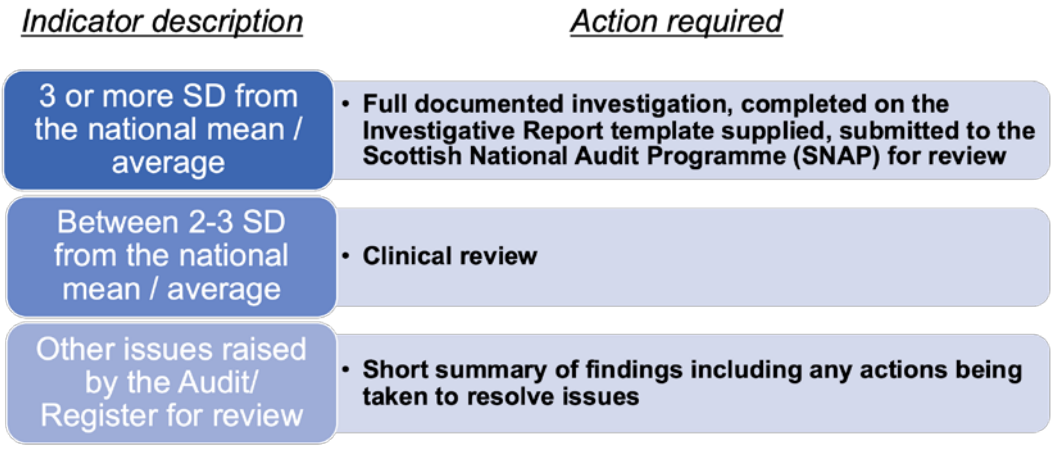


Figure 6.2 – Guide for SNAP reporting of indicators that are outliers from national means / averages

6.5 Stage 4 Escalation

In November 2019, NHSGGC was escalated to Stage 4 of the NHS Scotland Board Performance Escalation Framework in respect of 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. An Oversight Board was established in December 2019 to address the QEUH/RHC issues, chaired by Professor Fiona McQueen, the then Chief Nursing Officer reporting to the Chief Executive Officer of NHS Scotland. The final report of the Oversight Board, was published in March 2021. A specific delivery group (Gold Command), chaired by the Chief Executive, has been established to provide updates to the Corporate Management Team and, in turn, to the appropriate governance committee of the NHS Board to ensure focused work is undertaken on all of the recommendations.

In January 2020, NHSGGC was escalated to Stage 4 of the NHS Scotland Board Performance Escalation Framework in respect of scheduled care, unscheduled care, primary care out of hours, and culture and leadership. A Performance Oversight Group was established on 27th January 2020 to ensure the development of a robust Recovery Plan by NHSGGC to support the Board to move to an improved position on the key performance areas quickly. NHSGGC were tasked with the development and delivery of a single recovery plan with clear milestones to encompass the relevant areas. A report was submitted to the Scottish Government outlining the progress made in relation to each of the relevant areas highlighting that all actions have been progressed with the majority implemented and supported by marked improvements in performance. Formal notification from Scottish Government was received in June 2021 that the Board had been de-escalated from Level 4 to Level 2 in respect of these matters.

6.6 Public Inquiry

The Scottish Hospitals Public Inquiry was launched in August 2020. 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.

In January 2021 Lord Brodie announced timescales for 2021 and on the 1st February 2021 issued core participants with formal evidence requests. The first formal hearing of the Inquiry took take place on Tuesday 22nd June 2021.

The first substantive hearings of the Inquiry will commence on Monday 20th September 2021 and will last for five weeks. The focus of this first set of hearings is to enable the Inquiry to understand the experiences of affected patients and their families and it is those patients and families who will form the core of those called upon to give evidence in person at the initial hearings.

6.7 Next Steps

Assurance: Next steps 2021/22

- Future planning is underway to decide how to host and showcase data dashboards with a SharePoint site build.
- A dashboard build is underway for pre-release HSMR data that will accompany the quarterly reports for the pre-release data.
- A collaboration with colleagues from Knowledge Services and e-Health has been formed, to create a new instance on the Right Decision platform to host the Clinical Guideline Directory.
- A new quarterly report on breached guidelines has now been drafted and shared with Divisional level groups. This will evolve further during this year to provide corporate oversight.
- Conclude review and update of the NHSGGC Framework for Addressing Clinical Quality Publications, following consultation.

7 Person-Centred Care

7.1 Summary of Key Achievements

Person-Centred Care: Key Achievements 2020/21

- Between March 2020 and August 2020 the PCVV service was implemented in 314 locations across 19 sites, across NHSGGC, with over 600 iPad's deployed.
- The establishment of virtual visiting has provided the opportunity to maintain; where possible the pivotal role family members and those closest to the patient normally play in supporting patients.
- During COVID-19 visiting arrangements in all our in-patient hospitals has been underpinned by local guidance and risk assessment based on the national 'Visiting Guidance for Hospitals in Scotland.'

Person-Centred care aims to provide care that is responsive to individual personal preferences, needs and values and ensure these guide all decisions about care and treatment.

In response to COVID-19 restrictions, the work of the Person-Centred Health and Care (PCHC) team was modified according to needs over the reporting period.

7.2 Care Experience Improvement Model

The Care Experience Improvement Model (CEIM) was suspended temporarily in response to the COVID-19 pandemic in March 2020. Plans are underway to engage with clinical services with the aim of re-establishing the model in a small cohort of clinical teams in autumn 2021. Support to take forward improvement work in these clinical teams will be aligned to the Excellence in Care Standard / Care Assurance Standard for Person-Centred Care. In addition, the CEIM will be used to gather experience from patients, family and staff as we remobilise our approach to person-centred visiting and person-centred care planning and will help to inform improvements taken forward.

7.3 Person-Centred Care Planning

The programme of work for person-centred care planning was temporarily suspended in March 2020 in response to the COVID-19 pandemic. Plans to remobilise the project plan are in place for Summer 2021. Initially this will include engagement exercises using a survey approach and via virtual focus groups to gather experience, thoughts and ideas from patients, family, carers and staff to inform the development and testing of a small set of core principles to support a more consistent approach to person-centred care planning in all areas across NHSGGC.

7.4 What Matters To You?

The PCHC team coordinated NHSGGC activity for What Matters To You? Day on 9 June 2020 (WMTY20), including; distribution of resources to support local team activity,

production of a video showcasing staff talking about what mattered to them, speaking to staff in Rest and Relaxation hubs, and inviting patients, families and staff to share electronically what mattered to them.

All responses received via the PCHC team were collated and analysed to understand what mattered to people on WMTY20. In total, we found out what mattered to around 1000 people on WMTY20. Key themes were relationships, wellbeing, and human behaviour/ interaction.

The key learning from WMTY20 was collated into a short report with recommendations, and used to support increased activity, visibility and planning for WMTY21, with a renewed focus on asking, listening and **doing** what matters.

7.5 Person-Centred Visiting

Prior to the pandemic, the implementation of Person Centred Visiting (PCV) was in place across the majority of NHSGGC adult acute inpatient areas. This was a commitment of NHSGGC's Quality Strategy and a key objective of the Scottish Government. However as a consequence of the COVID-19 pandemic, it was necessary to impose strict restrictions on visiting. The PCV programme of work was therefore put on hold temporarily.

During the pandemic visiting across all in-patient areas in NHSGGC has been in accordance with National Guidance from the Scottish Government to align with the national strategic protection levels. This required specific local visiting guidance, risk assessments and visiting information to be developed and updated on a frequent basis. In addition, to support essential visits particularly for end-of–life care separate bespoke guidance was developed to underpin national guidance as well as the local application of this.

The remobilisation of our approach to person-centred visiting will be guided by national guidance from the Scottish Government when local authorities within NHSGGC reach level zero of the strategic protection levels. This is anticipated to be 19th July 2021 at the earliest.

7.6 Person-Centred Virtual Visiting

Person-Centred Virtual Visiting (PCVV) was established in all hospital wards in NHSGGC in response to the necessary visiting restrictions introduced by the Scottish Government during the COVID-19 pandemic. It was vital during this time that we continued to find ways to support patients to see and talk with the people who matter most to them. It was well recognised that whilst the majority of people have their own phone or tablet, there are those who do not have access to technology and therefore more vulnerable to isolation, loneliness and not able to access support from family and friends.

In March 2020 a formal approach to implementing PCVV was commenced, aiming to create consistency and equity of opportunity across hospital sites and services and ensure that we were addressing any areas where inequality existed.

Between March 2020 and August 2020 the PCVV service was implemented in 314 locations across 19 sites in NHSGGC with over 600 iPads deployed.

Pictures – Wards receiving their PCVV iPads

The establishment of virtual visiting has provided the opportunity to maintain, where possible, the pivotal role family members and those closest to the patient normally play in supporting patients. This includes contributing to care planning discussions, rehabilitation sessions with the AHP team and discharge planning discussions as well as providing insight and feedback on an individual's progress and alerting healthcare staff to changes they can see from a normal baseline. When an individual is acutely unwell and perhaps not able to participate independently in care discussions or their cognitive ability prevents this family involvement is crucial.

The following are a selection of experiences shared about person-centred virtual visiting from patients, family and staff. Themes were identified about the difference the service made to patients and those who matter to them from 211 feedback responses received in the period between April 2020 and March 2021 and are highlighted below.

Theme observed (and frequency)	*Illustrating excerpt*
They felt a closeness and connection through visual contact (n=63).	*"Staff feel that it has helped the patients maintain contact with their relatives whilst in hospital and the added bonus of them being able to visually see their relative is fantastic, especially at a time when visitors are not allowed in hospital." (11/06/2020)*
They felt less lonely and anxious (n=31).	*"It gives the patients a real sense of relief to know that they can speak to the family and see them face to face when we can't allow them to be beside their loved one. The patients feel more relaxed and not as anxious as we have this means of communication." (08/06/2020)*

PCVV provided a source of fun and happiness in a hard place (n=27).	*"The impact is palpable. Seeing patients faces light up with smiles and laughter of happiness is really very special and has kept our patients upbeat during a time of uncertainty." (28/04/2020)*
It enabled them to share more of their life with each other (e.g. celebrations, sharing surroundings) (n=15).	*"It was emotional for staff to see the relief from the family where they could see their mum looking happy with others around her, music in the background and the TV on, and a sense of the feel-good factor in the room. The Patient had a positive and passionate conversation where their face was so happy and relieved, it was amazing. […]" (08/06/2020)*
They felt able to see how each other are doing (n=26).	*"It made a huge difference to speak face to face. Speech problems often go along with a stroke so it was reassuring to see my friend, to see her room and to be able to report back to her family. [...]" (07/09/2020)*
They were enabled to remain a part of the patient's care (n=20) and see that they are being cared for (n=5).	*"The experiences have been very positive for staff, relatives and patients and are a great tool for using to keep all involved and up to date with progress of patients. We are planning to use for meetings with families when discussing complex discharge plans with relatives and MDT." (08/06/2020)*
	"Allowed daughter to see her mum and help assess any improvement in her delirium. Also allowed her to communicate in patient's native language. I was able to complete the What Matters to Me board along with her daughter and show her that her mum was being well looked after. Very positive experience." (27/04/2020)

Whilst PCVV should never be considered as a substitute for in-person visiting, PCVV will be maintained as an integral part of our approach to person-centred visiting longer-term. This will enable patients separated geographically, due to their hospital admission, from their family or where family are not able to visit as frequently as they would like due to personal and work commitments to remain in virtual contact.

A full Implementation, Activity and Evaluation report for PCVV is available here.

Photo: Ronald Black

A patient using a PCVV iPad mounted in a cart, enabling hands-free operation

7.7 Next Steps

Person-centred care: Next steps 2021/22

- As person-centred visiting is reintroduced in line with removal of COVID-19 restrictions, PCVV will be integral to our approach. Ward staff will be further supported to discuss the option with patients and their family to have a virtual visit using the 'who matters to you' conversational inquiry, if in-person visits are not possible.
- Engagement with clinical services will commence in Summer 2021 to remobilise the Care Experience Improvement Model to gather experiences from patients, family and carers to identify examples of best practice, guide and influence improvement.
- Full implementation of the Person-Centred Care Planning improvement work will commence in Summer 2021.

8 Conclusion

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

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

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