NHS Greater Glasgow and Clyde

# Clinical Governance Annual Report

## 2022-2023

August 2023

# Contents Page

# 1. Introduction

We are pleased to present the NHSGGC Clinical Governance Annual Report for 2022-2023. This report presents a 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.

The report covers the period April 2022-March 2023 and highlights some of our achievements and key activities throughout the year, as well as outlining priority areas for the year ahead.

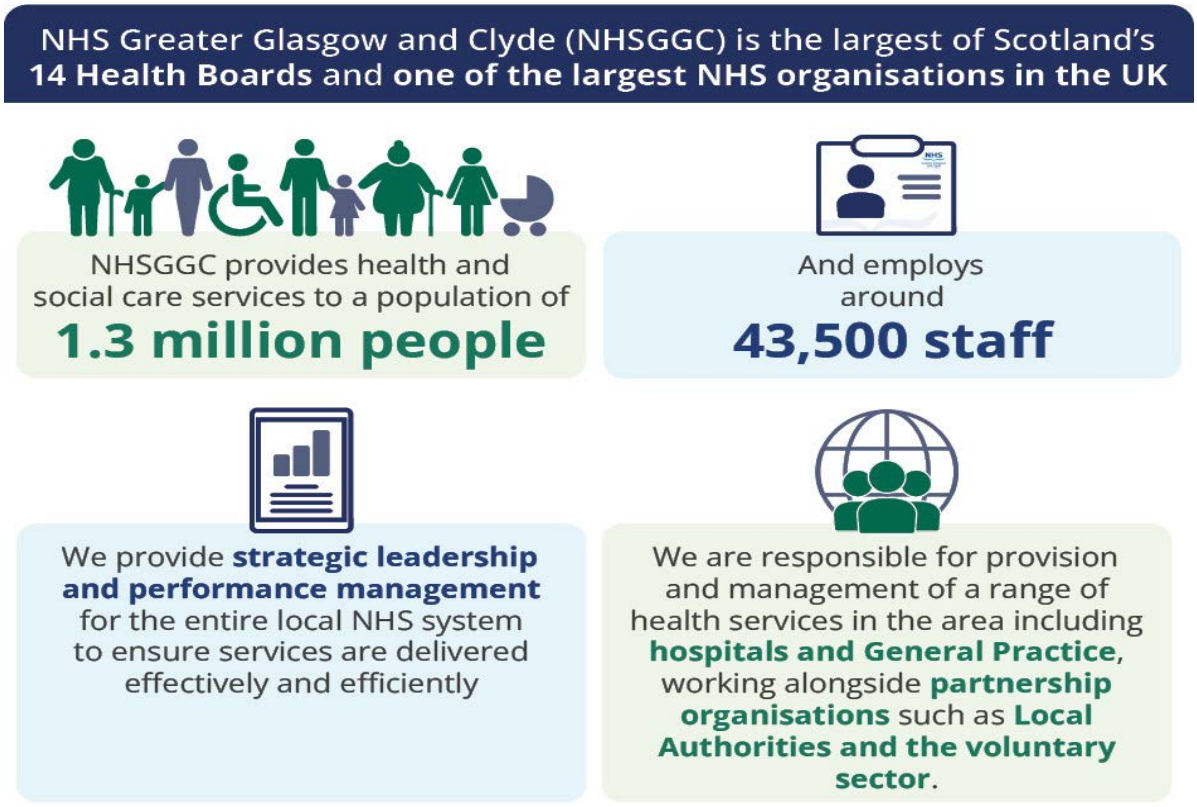
A detailed update on person-centred care is contained within the NHSGGC Quality Strategy Annual Report 2022-2023.

# 2. Clinical Governance Arrangements

## 2.1 NHS Greater Glasgow and Clyde purpose

**NHS Greater Glasgow and Clyde's** purpose is:

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




## 2.2 Clinical Governance in NHS Greater Glasgow and Clyde

Our commitment to improving the quality of care is central to the way we work within NHS Greater Glasgow & Clyde (NHSGGC). Our ambition to provide high quality care is informed by the statutory Duty of Quality. The Duty of Quality applies to all services we provide in connection with the prevention, diagnosis or treatment of illness. The framework of arrangements we put in place to meet this Duty of Quality, and all its associated activities, is referred to as Clinical Governance.

The Health Act 1999 requires that NHSGGC "put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals".

The Chief Executive has overall responsibility for the delivery of clinical governance within NHSGGC and delegates this responsibility through general management structures, complemented by the Board's clinical governance arrangements.

The NHSGGC Clinical Governance Structure is outlined in Figure 2.1

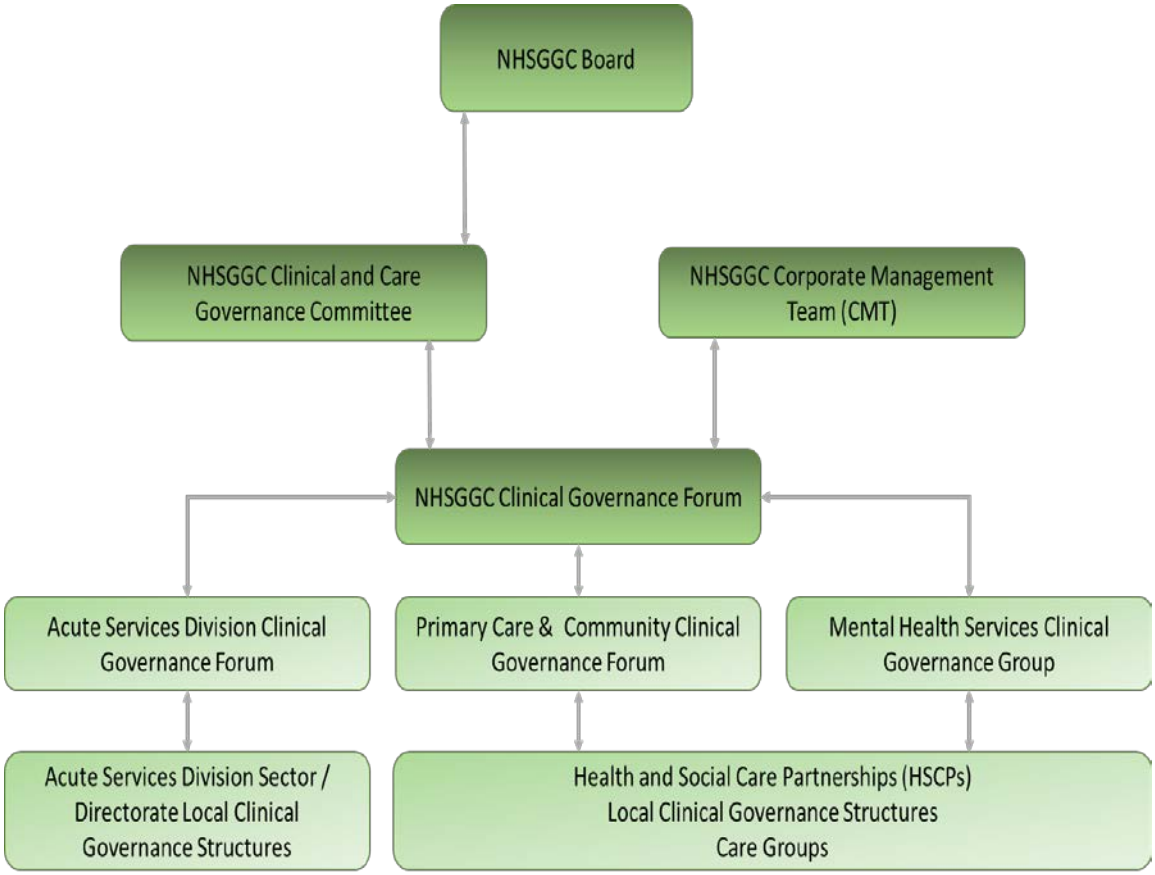



*Figure 2.1 – Clinical Governance Structure*

## 2.2.1 The NHSGGC Clinical and Care Governance Committee

Our current clinical governance arrangements consist of a Clinical and Care Governance Committee established in accordance with NHS Greater Glasgow and Clyde Board Standing Orders and Scheme of Delegation and is a Standing Committee of the NHS Board. The overall purpose of the Clinical and Care Governance Committee is to provide assurance across the whole system regarding clinical and care governance ensuring escalation to the NHS Board.

### 2.2.2 The NHSGGC Board Clinical Governance Forum

The purpose of the Board Clinical Governance Forum (Board CGF) is to scrutinise, seek assurance and provide onward assurance regarding clinical governance to the Corporate Management Team and Clinical and Care Governance Committee. The Board Clinical Governance Forum (Board CGF) is chaired by the Medical Director.

### 2.2.3 Divisional Clinical Governance Forums/Groups

The essential function of the Divisional Clinical Governance Groups (Acute, Mental Health and Primary and Community Care) is to support the delivery of consistently high quality clinical care and to provide assurance that appropriate clinical governance mechanisms are in place.

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.

## 2.3 Clinical Governance Arrangements - Key activities during 2022-2023

Meetings of the Clinical and Care Governance Committee, Board, Acute, Mental Health, and Primary and Community Care Clinical Governance Groups have all been maintained during 2022-23.

Some of our key activities in 2022-2023 to review and strengthen our clinical governance arrangements include:

- The Terms of Reference and annual cycle of business for the Board CGF have been reviewed and approved. In line with the cycle of business, the group receive a series of standing reports, covering the following

  Reports from major services and key systems in clinical governance
  - Acute Services Division
  - Primary Care & Community Care
  - Mental Health
  - Pharmacy and Prescribing
  - Research & Innovation
  - Public Protection
  - Infection Prevention and Control

  Themed Assurance Reports
  - West of Scotland Cancer Clinical Quality Indicators
  - HSMR
  - Clinical Risk
  - Clinical Guidelines
  - Safety and Quality Programmes (including KPIs)
  - Clinical Quality Publications, Red Flags and SNAP outliers

- Complaints, Ombudsman, Patient Feedback, Person Centred Care Improvement Programme

Identified Service & Programme Reports
- Prisoner Healthcare
- Child Death Review Programme
- Unscheduled Care
- Maternity, including outcome data on stillbirths, neonatal and perinatal deaths.

Annual Reports
- Clinical Governance
- Duty of Candour
- Research and Innovation/West of Scotland Research Ethics Committees
- Scottish National Audit Programme Annual Governance Overview
- Controlled Drug Governance Annual Report

Clinical Guidelines/Policies for approval
- Tabled on agenda as required for approval

Scrutiny, Regulatory Body, Quality and Safety Related Externally Led Inquiries, Reviews and Inspections.

- The NHSGGC Clinical Governance policy has been reviewed, updated and was approved by the Corporate Management Team in July 2023.
- The Acute Clinical Governance Forum (Acute CGF) has reviewed the reporting template, completed by every sector/ directorate, which provides an update to the forum in relation to Safe, Effective and Person-Centred Care. A new template is currently being tested, which seeks to update on a number of priority areas identified via Acute CGF, as well as providing key updates, progress reporting and, highlighting any issues, challenges or general learning/improvements to be shared. The Terms of Reference and Reporting Schedule have been reviewed and approved.

## 2.4 Clinical Governance Policies and Frameworks

There are a range of policies, strategies and frameworks which underpin the approach to clinical governance and quality within NHSGGC. A selection of the key documents are outlined below.

### 2.4.1 NHSGGC Clinical Governance Policy

The NHSGGC Clinical Governance Policy sets out the key policy requirements and the organisational arrangements for clinical governance. Monitoring of the policy is maintained through the clinical governance structures, linked to the NHSGGC Clinical and Care Governance Committee and the NHS Board.

## 2.4.2 NHSGGC Policy and Procedure Duty of Candour Compliance

The organisational Duty of Candour procedure is a legal duty to support the implementation of consistent responses across health and social care providers where there has been an unexpected event or incident that has resulted in death or harm, or could result in death or harm, where the outcome relates directly to the incident rather than the natural course of the person's illness or underlying condition.

Provisions in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 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 such an incident has occurred.

## 2.4.3 NHSGGC Policy on the Management of Significant Adverse Events

The NHSGGC Policy on the Management of Significant Adverse Events sets out the basic principles and key requirements for identifying, reporting, investigating and learning from significant adverse events.

## 2.4.4 NHSGGC Healthcare Quality Strategy

Pursuing Excellence in Healthcare: NHS Greater Glasgow and Clyde Healthcare Quality Strategy is a framework which outlines how NHSGGC intends to continuously improve the quality of care to our patients, carers and communities.

## 2.4.5 NHSGGC Clinical Guidelines Framework

The NHSGGC Clinical Guideline Framework sets out the principles of guideline development and approval within NHSGGC for both medicine and non-medicine related guidelines. The Framework aims to ensure that clinical guidelines:

- reflect best practice, and that all key staff are involved in their development and agreement
- are reviewed and approved by an appropriate group
- are up to date and kept under regular review

## 2.4.6 NHSGGC Framework for Addressing Clinical Quality Publications

The NHSGGC Framework for Addressing Clinical Quality Publications aims to ensure the Board is aware of the most recent publications; to provide assurance that the current position in relation to publications is known; and that any actions in response to the publication can be agreed.

Clinical Quality Publications (CQPs) are defined 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.

### 2.4.7 NHSGGC New Interventional Procedure Policy

An interventional procedure is used for treatment or diagnosis and involves incision, puncture, entry into a body cavity, electromagnetic or acoustic energy. NHSGGC New Interventional Procedures Policy sets out the approach to be taken in relation to the introduction of new interventional procedures within the Board and is designed to enable health care professionals to embrace new technologies whilst protecting patients and reducing risk.

# 3. Key Messages

## 3.1 Safe Care

- The usual clinical risk management arrangements were maintained throughout the period from April 2022 to March 2023.
- In 2022/23, NHSGGC saw a rise in the number of SAERs awaiting a commissioning decision. There has also been an overall increase in the delays with concluding SAERs. Work is continuing to review and reduce SAER delays across NHSGGC through the use of the Datix dashboard, improvement plans and increasing the number of staff trained in lead investigator techniques. Five Significant Adverse Events Key Performance Indicators (KPI) were agreed in December 2022 to further support reporting and monitoring of progress with the management of significant adverse events.
- There were 35 incidents where Duty of Candour applied. Full compliance was achieved for all concluded duty of candour incidents.
- The Significant Adverse Event Review (SAER) Toolkit was reviewed in 2022/23, in preparation for the review of the NHSGGC Policy on the Management of Significant Adverse Events in 2023.
- SAER Commissioner Training was developed for staff across NHSGGC.
- The current Datix Incident Management System is approaching decommissioning and a full National Procurement exercise is underway, led by NHS National Services Scotland to establish a national framework for all Scottish Health Boards.

## 3.2 Effective Care

- Progress with work on the Quality Improvement programmes across Acute Services, Mental Health and Primary Care continued through the period April 2022 to March 2023. The key focus was to further develop the infrastructure, develop robust data processes and engage with clinical teams to progress the improvement work.
- Over 2000 staff have completed the QI Fundamentals LearnPro module since its launch in February 2021
- 11 cohorts of the Scottish Improvement Foundation Skills (SIFS) virtual quality improvement training have been delivered to 130 staff across NHSGGC.
- 25 staff from NHSGGC have secured places on national QI training programmes.
- The NHSGGC Clinical Guideline Framework was reviewed, approved and republished in February 2023.
- Processes to develop and review clinical guidelines remain in place. As at 31st March 2023, there were 773 clinical guidelines on the platform, 70% of which are within their review date. Actions have already been put in place to reduce the number of breached guidelines (warning banners on the guidelines themselves; revised escalation process; support to lead authors/ governance groups) and the year ahead work will be taken forward to review and improve the processes for review of clinical guidelines, with the aim of reducing the number of breached guidelines to below 5%.

- In 2022/23 we increased promotion of the Right Decision Service Platform for Clinical Guidelines. The commencement of awareness roadshows introduced more people to the resource and the development of newsletters has kept stakeholders abreast of changes. This has resulted in a 150% increase in the total number of users of the platform (from 5398 in April 2022 to 13,503 in March 2023).
- An Evaluation Toolkit has been developed and launched, bringing together helpful tools and resources into one interactive space.

# 4. Safe Care

## 4.1 Clinical Risk Management

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).

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 (SAER) is tracked from the initial report through a managed process to confirmation that any resulting actions are complete.

### 4.1.1 Significant Adverse Event Reviews (SAERs)


In total 336 SAERs were commissioned between April 2022 and March 2023, which includes 320 incidents occurring in that year with 16 incidents commissioned from previous years. This compares to 262 incidents commissioned in 2021/22 from incidents occurring in all years.

Figure 4.1 shows the number of SAERs from April 2014 to March 2023. There were 320 clinical incidents which triggered a SAER with an incident date occurring between April 2022 and March 2023. This is an increase of 74 incidents from the previous year, which may be in part attributable to the publication of the Maternity and Neonatal (Perinatal) Adverse Event Review Process for Scotland in September 2021, which outlined those events which now require a SAE. In addition, there has been an improvement focus taken to for the commissioning and completion of SAERs during 22-23.

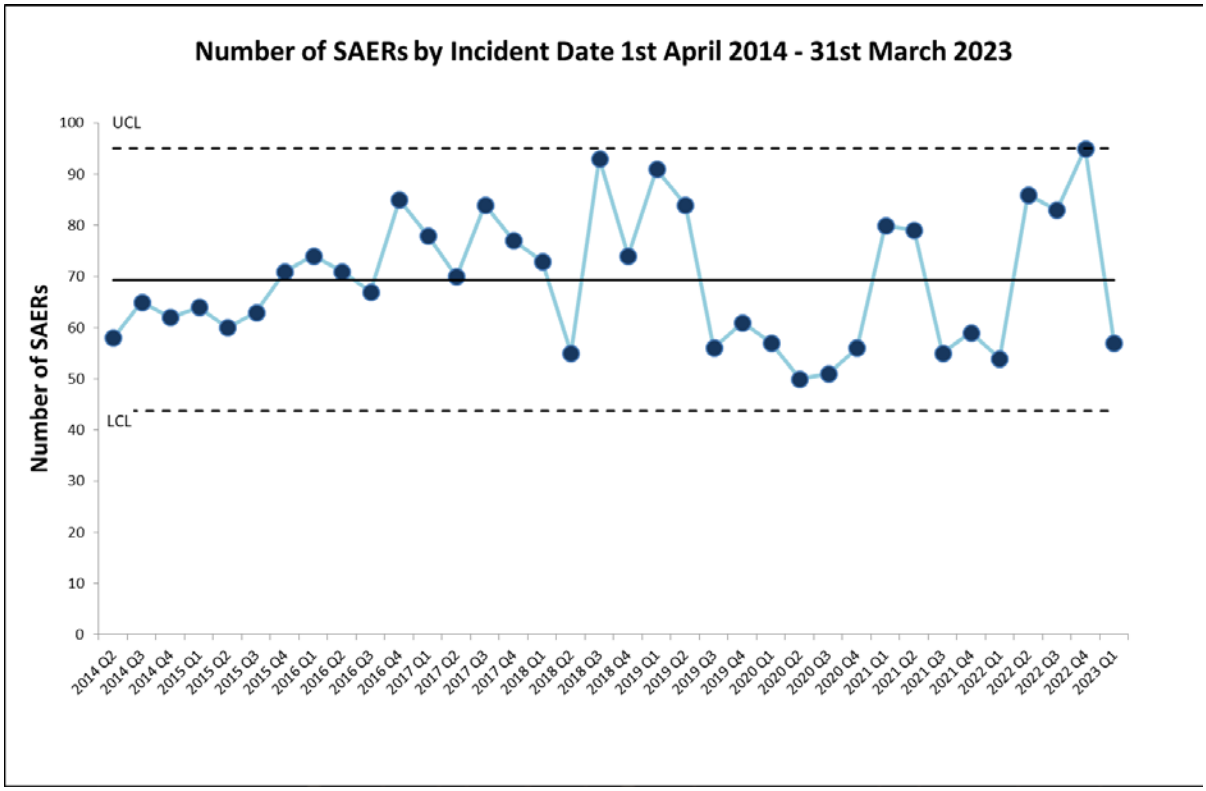



*Figure 4.1 – Number of Significant Adverse Event Reviews per quarter from 2014 to 2023*

In 2022/23, NHSGGC saw a rise in the number of SAERs awaiting a commissioning decision. There are 371 incidents with an incident date between 1 April 2022 and 31 March 2023 awaiting a decision on whether to commission a SAER. A further 162 incidents with incident dates before 1st April 2022 have outstanding decisions. That is a total of 533 incidents awaiting a decision whether to commission a SAER, therefore the number of SAERs commissioned from incidents in this and previous years may rise.

There has also been an overall increase in the delays concluding SAERs, the reasons for which are multifactorial. Work is underway to reduce SAER delays across NHSGGC through the use of the Datix dashboard, improvement plans and increasing the number of staff trained in lead investigator techniques.

Five SAE key performance indicators were agreed by Chairs of the Divisional Clinical Governance Groups in December 2022 to further support reporting and monitoring of progress with the management of significant adverse events. Data for each of the key performance indicators is reported monthly to Divisional Clinical Governance Groups. The key performance indicators are;

- KPI 1: SAERs commissioned within 10 days of incident date
- KPI 2: Number of potential SAERs
- KPI 3: Number of open SAERs
- KPI 4: SAERs which remain open after 12 months from incident date
- KPI 5: Number of SAERs closed (closed within 90 days of incident date)

## 4.1.2 Significant Adverse Event Review Outcomes

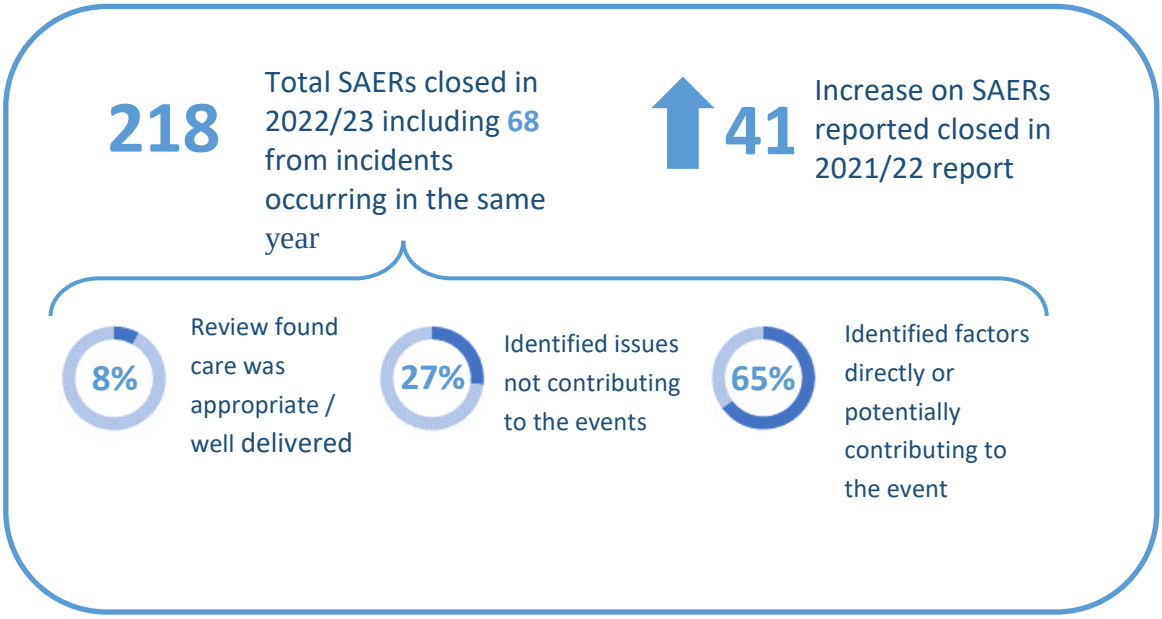
The review aims to examine the processes of care to identify if any clinical system failures occurred which contributed to the incident and the patient outcome. This understanding is vital if the learning from these incidents is to be realised.

Where clinical system failures are identified, causal analysis should be undertaken to further understand why and how these can be managed to prevent recurrence. An investigation should consider how significant this failure has been in the overall incident (i.e. if multiple failures how they relate to each other) and also how they impacted on the patient and subsequent outcome.

It is recognised that not all incidents investigated will identify clinical system failures and may find appropriate care was delivered, the potential for learning in these cases should also be recognised and areas of good practice shared appropriately.

To support this part of the process, all investigations will conclude one of the following investigation causation codes:

| **Investigation Conclusion Code**<br>*This is not the patient outcome* | |
|---|---|
| 1 | Appropriate Care: well planned and delivered |
| 2 | Issues identified but they did not contribute to the event |
| 3 | Issues identified which may have caused or contributed to the event |
| 4 | Issues identified that directly related to the cause of the event |



## 4.1.3 Contributory factors and thematic analysis from Significant Adverse Event Reviews

### What contributed to these events?

Every SAE review includes the theming of factors which contributed to any issues identified. Across the 218 SAERs completed in 2022/23, review teams identified:

**Team, Social and Communication** factors were found in **85%** of SAERs, with issues identified including inter-team communication, handover problems and documentation.

**Task** related factors were found in **60%** of SAERs, with issues predominantly related to the following of established guidance.

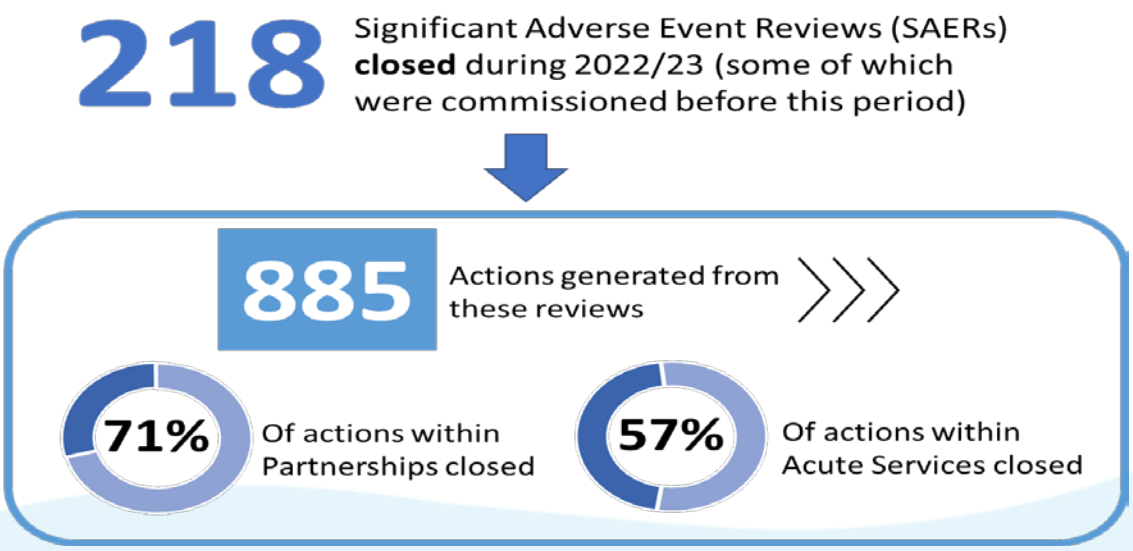
**Individual** factors were found in **53%** of SAERs, with issues including error in judgement, distractions and new or unfamiliar situations.

**Patient** factors were found in **41%** of SAERs, with issues including complexity of condition, cognitive impairment and social/family factors.

**Equipment & Resources** factors were found in **29%** of SAERs, with issues identified including staffing and workload.

**Management & Organisational** factors were found in **26%** of SAERs, with issues identified including poorly designed processes and cross-site/organisation working

## 4.1.4 Recommendations from SAERs



## 4.2 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.

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.
- Apologise 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.

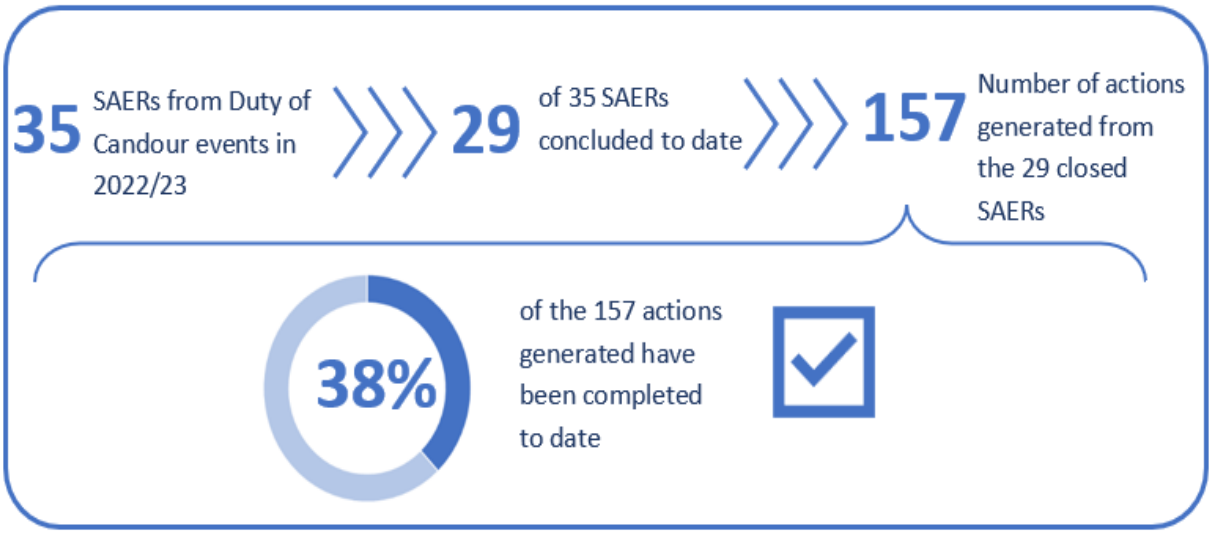
There were 35 incidents which occurred between 1 April 2022 and 31 March 2023 where the Duty of Candour applied.

| Outcome of unexpected or unintended incident | Number of times this happened |
|---|---|
| A person died | 9 |
| A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions | 2 |
| A person's treatment increased | 23 |
| The structure of a person's body changed | 1 |
| A person's life expectancy shortened | 0 |

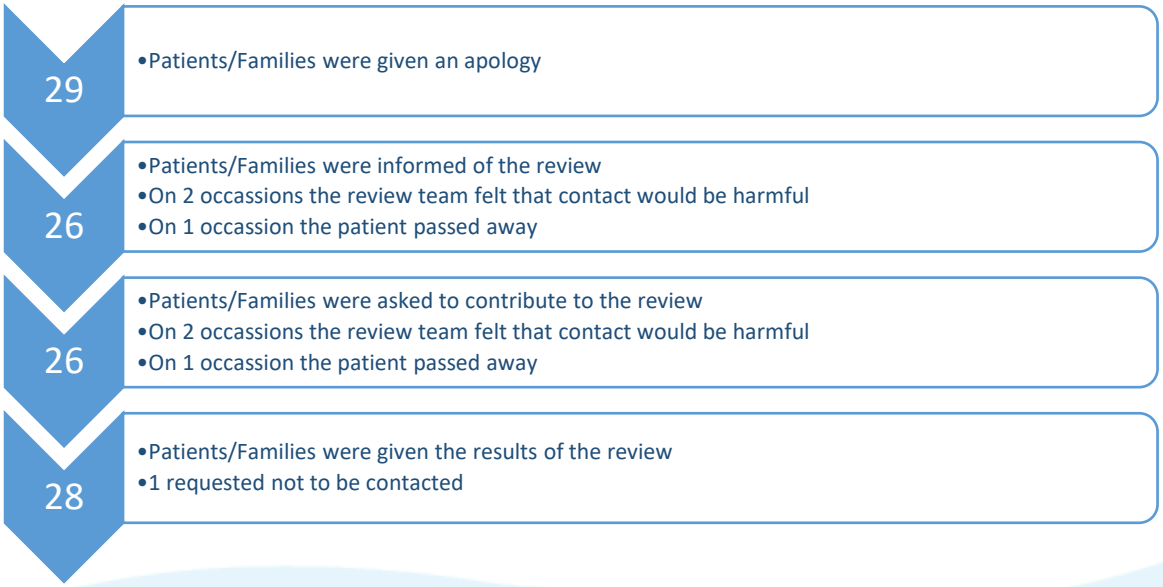
| | |
|---|---|
| A person's sensory, motor or intellectual function was impaired for 28 days or more | 0 |
| A person experienced pain or psychological harm for 28 days or more | 0 |
| A person needed health treatment in order to prevent them dying | 0 |
| A person needed treatment in order to prevent other injuries as listed above | 0 |
| **Total** | **35** |

*Table 4.1 – Outcomes of incidents where the Duty of Candour applied 2022-23*

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




Full compliance was achieved for all concluded duty of candour incidents.



### 4.2.1 Duty of Candour Update from 2021/22

The 2021/22 Duty of Candour annual report with addendum update, reported 41 incidents within the reporting period that triggered Duty of Candour. At the time of writing the 2021/22 Duty of Candour annual report, 38 of these incidents had been closed. Since the report was published a further 44 incidents have now been closed therefore the total number of duty of candour events dated 2021/22 was 82. This was due to investigations which were still ongoing at the time of compiling the annual report and the further addendum report.

## 4.3 Training

### 4.3.1 Significant Adverse Events Reviewer Training

Significant Adverse Events Reviewer Training (formerly known as Root Cause Analysis) is training provided to staff across NHSGGC to support them when reviewing SAERs.

Between 2018 and 2021, this training was provided on a face-to-face basis and during this three year period, 17 courses were run and 220 staff completed the training. In 2022, the training was moved to a virtual delivery and 6 courses were delivered to 290 staff in 2022. A further 3 courses were delivered to 268 staff between January and May 2023.

### 4.3.2 Duty of Candour Training

To support NHSGGC staff to understand the Duty of Candour legislation and ensure providers are open and transparent with people who use services, NHS Education Scotland developed an online course which is available through Learnpro. 34 staff within NHSGGC have completed the NES Duty of Candour Course between April 2022 and March 2023.

### 4.3.3 Commissioner Training

An education module has been developed to assist SAER Commissioners with their role within the SAER process. LearnPro Module 305: Commissioning of a Significant Adverse Event was launched in May 2023 and 57 staff completed the module within the first month following the launch.

## 4.4 Morbidity and Mortality

A morbidity and mortality meeting provides an opportunity for clinicians to review the quality of care provided, in an open forum with peers and colleagues, by examining recent case studies. These may be complex cases that have been well managed, complications, or an unexpected event such as deterioration or patient death. These meetings support a systematic approach to the review of healthcare, with the aim of improving patient care and also providing professional learning and development. A module was developed on the electronic risk management system for recording and managing these meetings.

The most recent update to the Acute Services Division was in March 2023 where there were 21 specialities reported to be using the M&M module, this data presented the position at end of 2022. It was agreed then that Sectors and Directorates should include the improvement of their M&M processes on their clinical governance work plans. As part of this Sectors and Directorates would review current arrangements across the specialties to identify where improvements are required.

There are currently 24 specialities now using the system. Each sector have agreed to review their own use of the system and provide updates through the clinical governance escalation templates that are tabled at the Acute Services Division Clinical Governance Forum.

An evaluation of the system is underway.

## 4.5 Datix

Datix is a web-based risk management 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. The risk management system also helps to improve patient safety, through effective reporting, management and review.

Datix allows incidents to be reported in real time and is open to all staff via Staffnet. The reporting form is designed to enable ease of use, with many of the options based on drop down tables. Help and support is available from the Datix support team.

### 4.5.1 Procurement for a new NHSGGC Risk Management System

The current Datix system is approaching decommissioning and a full National Procurement exercise is underway, led by NHS National Services Scotland (NHSNSS) to establish a national framework for all Scottish Health Boards. This competitive process has been narrowed down to three suppliers with a submission date of 31st March 2023.

### 4.5.2 Risk Registers

In 2022 a review of the current risk register module in Datix was undertaken alongside the development of the new NHSGGC Risk Management Strategy and Risk Register Policy and Guidance. The new NHSGGC Risk Management Strategy, Risk Register Policy and Guidance were approved by the Board in December 2022. In support of this and to ensure organisational consistency, updates were made to the risk register form on Datix, including re-integration of the Corporate Risk Register and adoption and reporting of an Enterprise Risk Management model for the organisation. Training sessions took place to support staff with the new form and workflow.

### 4.5.3 Datix Data Quality Improvement

In collaboration with eHealth, a quality improvement project to improve the accuracy of the patient demographic data on Datix was undertaken. This work involved CHI seeding the patient data and merging any duplicate records. This enables more

accurate reporting at individual patient level for the service. A six-monthly schedule has been put in place to monitor, measure and merge any duplicate patient records.

### 4.5.4 Support to End Users

6,287 Datix support requests from staff were resolved over the last year. These vary in nature and include setting up new user accounts, training, system changes, rejecting duplicate incidents, creating reports and provision of data to fulfil Freedom of Information requests. To further support staff in using Datix several masterclass training sessions were run via MS Teams.

### 4.5.5 Communication

The Datix metrics report continues to evolve with additional quality indicators being added to identify any themes, opportunities for improvement or shared learning. The reports are based on Key Performance Indicators (KPI) which were developed on recommendations set out in the Queen Elizabeth University Hospitals/Royal Hospital for Children Oversight Report. A summary report is shared through the Acute, Primary Care and Mental Health Clinical Governance for assurance and escalation if required.

Key messages and learning from these reports are also shared with all Datix users through the bi-monthly Datix Bulletin.

# 5. Effective Care

## 5.1 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.

### 5.1.1 Scottish Patient Safety Programme (SPSP) Acute Adult Collaborative

Healthcare Improvement Scotland (HIS) launched the Scottish Patient Safety Programme (SPSP) Acute Adult Collaborative on the 22nd September 2021. The collaborative has two main areas of focus;

- early recognition and timely intervention for deteriorating patients
- reducing inpatient falls

The collaborative was due to come to an end in September 2023, however following discussions across all Health Boards nationally, Healthcare Improvement Scotland (HIS) extended the collaborative to March 2024.

**SPSP Deteriorating Patient**

The NHSGGC Deteriorating Patient Steering Group has met monthly since January 2022 and is co-chaired by the programme Medical Lead and Nursing Lead. The group continues to provide leadership and focus on the key areas of the programme which includes a review of the cardiac arrest dataset and processes, working with clinical teams to develop reliable processes around recognition and response to the deteriorating patient and to develop an improved approach to the use and completion of Treatment Escalation Plans.

The Steering Group receives monthly feedback from the clinical leads for the Royal Alexandra Hospital (RAH) and the Queen Elizabeth University Hospital (QEUH) concerning the participating test wards. The key focus at site level has been to:-

- Test and implement Call/Escalation boards
- Ensure all staff are fully trained around recognition of deterioration
- Review ward-based processes around early warning scores (NEWS2)
- Review processes around structured response to deterioration
- Ensuring all crash calls are recorded onto Datix

The outcome measure for the Deteriorating Patient programme is a reduction in the cardiac arrest rate. Quarterly data submissions to Healthcare Improvement Scotland (HIS) commenced in November 2021.

**SPSP Falls**

NHSGGC Falls Prevention and Management Steering Group was convened in 2021 and has oversight of falls prevention work across the organisation. An Acute Falls Improvement Group acts as Steering Group for the Falls programme was set up in May 2022.

The key areas of focused work are around the national objective to provide consistent definitions of Falls and Falls with Harm, which involved participating in the a Delphi process to establish consensus nationally. Further to this, local work has been progressed around:-

- Introduction of Yellow Falls Visual Cues Kit into test sites
- Measurement of lying and standing blood pressure
- Testing a post-fall debrief tool and process
- Review of ward environment in Safety Walkround format
- Taking an approach to help understand how the hospital environment may need to adapt in order to support improved clinical care, reduction in falls and associated care needs.

The outcome measures for the Falls programme are:

1. Reduction in Inpatient Falls rate.
2. Reduction in Inpatient Falls with Harm rate.

Quarterly data submissions to Healthcare Improvement Scotland (HIS) commenced in November 2021.

## 5.1.2 Maternity and Children Quality Improvement Collaborative

Two of the SPSP programmes, Maternity and Neonates, are measuring and reporting on their key safety priority areas and regular monthly reports on progress are reviewed by the Director of Midwifery / Chief Nurse.

**Key priorities of the Maternity Programme for 2022/2023**

- Stillbirth
- Post-Partum Haemorrhage
- Preterm Perinatal Wellbeing

**Key priorities of the Neonatal Programme for 2022/2023**

- Neonatal Mortality
- Term Admissions
- Preterm Perinatal Wellbeing
- Bronchopulmonary Dysplasia
- Neurological Injury

In January 2023, a Maternity Programme Steering Group was established to create the vision and set the strategic direction for the Maternity Programme within the Board, in line with national direction.

At a national level, Healthcare Improvement Scotland (HIS) have coordinated a Maternity Expert Reference Group (ERG) and a Neonatal ERG to develop the national priorities for these programmes. Staff across NHSGGC have contributed to these groups.

In November 2023, the individual programmes for Maternity and Neonates will come to an end and will be succeeded by a new SPSP Perinatal Programme.

The SPSP Paediatric programme is also being redeveloped by HIS with driver diagrams out for consultation across all NHS Boards. This programme is expected to launch in September 2023.

### 5.1.3 SPSP Mental Health

HIS launched a new national SPSP Mental Health Improvement Collaborative on the 26th April 2022. The collaborative focuses on three main areas:

- Observation to Intervention
- Restraint
- Seclusion

Two NHSGGC Adult Mental Health wards continue to participate in this collaborative: Elgin Ward in Stobhill Hospital and the Intensive Psychiatric Care Unit (IPCU) in Leverndale Hospital. The improvement work being taken forward in these two pathfinder wards are around debrief following incidents of restraint and person-centred care planning. The national collaborative will come to an end in August 2023 and within NHSGGC, a local QI programme is in development to build on the work of the collaborative.

An SPSP Mental Health Short-Life Working Group was established in 2022 and continues to work with the two ward teams to develop the improvement programme and share learning. This group reports to the NHSGGC Mental Health Quality Improvement Group.

The Mental Health Quality Improvement Group (re-established in April 2022) continues to meet bi-monthly and report to the Mental Health Services Clinical Governance Group. The key focus for the group remains:

- NHSGGC Mental Health QI Programme including the Scottish Patient Safety Programme
- Accreditation for Inpatient Mental Health Services (AIMS) Programme
- Actions/Themes from Significant Adverse Events Review (SAER) recommendations
- Coordination of local QI projects across Mental Health Services
- Commission work based on feedback from national inspections, standards and guidelines.

## 5.1.4 SPSP Primary Care Programme

In NHSGGC, the focus of the SPSP Primary Care Programme was on the Primary Care Access Programme (PCAP). The local delivery test of the PCAP 7 week sprint model focused on Glasgow City HSCP with space to evaluate, reflect and learn from this method of delivery. The model involves 12 weeks of planning, which commenced in March 2023 followed by a 7 week sprint using a QI approach.

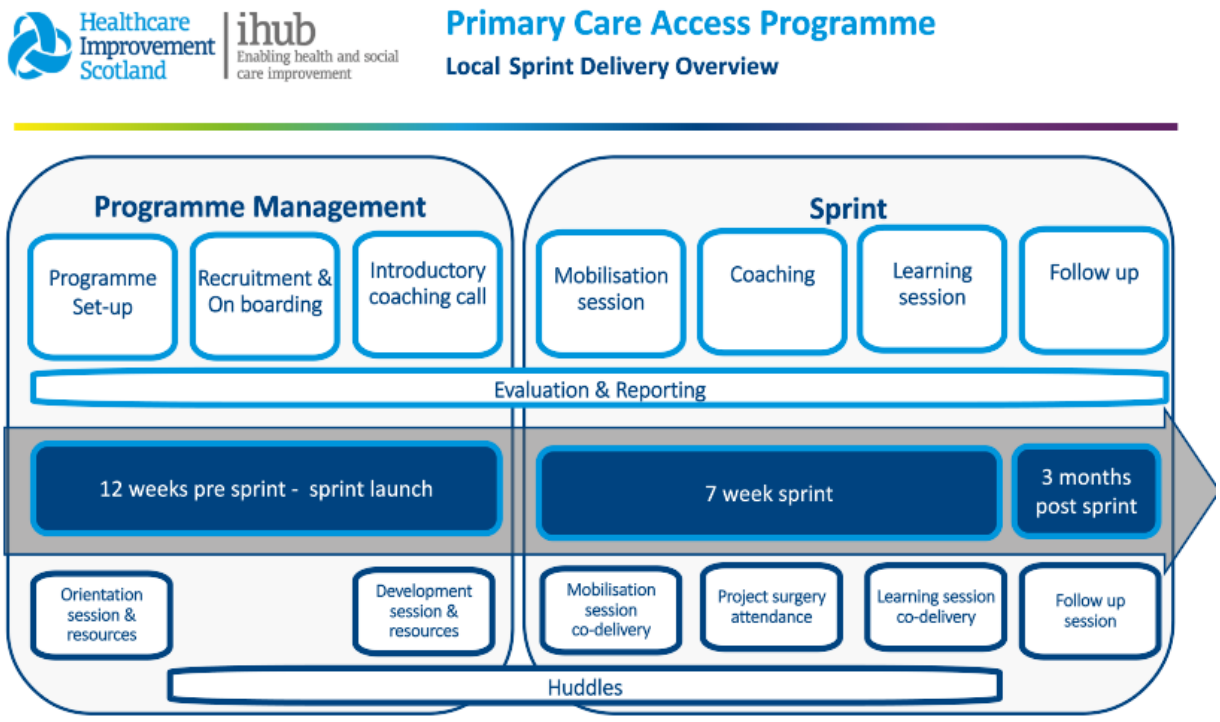



Image: courtesy of Healthcare Improvement Primary Care Portfolio team.

The test for Glasgow City HSCP involved a buddy coach system with a member of the Clinical Governance Support Unit (CGSU) and Glasgow City HCSP Primary Care Improvement Team. Programme support was provided by the HIS team.

The local delivery model created an opportunity for wider learning, networking and relationship building. There was also an opportunity for coaching teams and GP practices to review case studies and observe learning from other GP practices in Scotland.

### Primary Care Improvement Group

The group meets quarterly and has Multi-Disciplinary Team representation. One key focus of the group is mapping improvement priorities within GP clusters. This work was agreed in March 2023 and the first area to be mapped is East Renfrewshire. A newsletter has been created to help share information on QI work with quality cluster leads and the wider primary care sector.

In addition, a QI event focusing on remobilisation in Primary Care QI was undertaken in May 2023. This session was well attended and an array of topics were covered including Awareness of QI resources, local projects, Diabetes surveillance, Cervical Screening and access to appointments.

## 5.2 Quality Improvement Capability

The NHSGGC Quality Improvement Capability Plan 2021-23 was approved at the Healthcare Quality Strategy Oversight Group in October 2021. This plan provides direction on how to build the capacity and capability of staff in NHSGGC to use quality improvement methods to deliver high quality health and social care.

The key objectives of the QI Capability plan are:

1. Engagement and coordination: to identify those staff who are trained in QI and work with QI Leads across the organisation to identify gaps and build capability within services.
2. Support staff to apply for national QI training programmes: to highlight opportunities and coordinate applications for the key national QI training programmes, including the Scottish Quality and Safety Fellowship, Scottish Improvement Leader (ScIL) Programme and the Scottish Coaching and Leading for Improvement Programme (SCLIP).
3. Delivery and evaluation of local QI training programmes: to deliver cohorts of the Scottish Improvement Foundation Skills (SIFS) programme, develop and launch a Learnpro module on the fundamentals of QI, plan and deliver 2 local SCLIP cohorts and establish a local QI faculty to support QI trained staff to deliver training within their own services.

### 5.2.1 Engagement and coordination

A toolkit to support services to identify gaps and build QI capability was developed and tested with the Allied Health Professionals (AHP) QI Network. The toolkit will be used across Acute Sectors and Directorates and HSCPs to build an organisational map and local action plan to develop QI Capability in each area. This work is expected to be completed by October 2023.

### 5.2.2 National QI Training Programmes

Using a combination of local and nationally delivered QI training programmes, the number of NHSGGC staff trained at lead-level is shown in Table 5.1

| Type of Training | Number of current staff |
|---|---|
| Scottish Quality and Safety Fellowship | 30 |
| Scottish Improvement Leaders (ScIL) / Improvement Advisors (IA) | 51 |
| Scottish Coaching & Leadership for Improvement Programme (SCLIP) | 94 |

*Table 5.1: NHSGGC staff trained through QI programmes*

NHS Education Scotland (NES) recruited a new national cohort of the Scottish Quality and Safety Fellowship in February and March 2023. From NHSGGC, there were 7 applications submitted from Medical, Nursing & Midwifery and Management staff.

Following the shortlisting and interview phase, three successful applicants were selected for this programme.

Recruitment for a national cohort of the Scottish Improvement Leader (ScIL) concluded in April 2023. The ScIL programme enables individuals to design, develop and lead improvement projects. It emphasises the importance of understanding people and relationships in change and how to lead and influence for improvement. There were 20 staff across NHSGGC who applied for a place on cohort 45 and there were 6 successful applicants. These cohorts started in June 2023 and are due to complete in May 2024.

The Scottish Coaching and Leading for Improvement Programme (SCLIP) is a Quality Improvement learning programme aimed at developing individuals to coach and facilitate teams to deliver improvement and to support improvement strategies within organisations. 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. Recruitment for Cohort 33 of SCLIP concluded in February 2023 with 19 successful applicants from NHSGGC that will participate in a programme running from May to September 2023.

## 5.2.3 NHSGGC Quality Improvement Training

### Quality Improvement Fundamentals

A Learnpro Module was developed in 2021 to support NHSGGC staff to understand Quality Improvement. The module aims to provide awareness and basic understanding of the importance, methods and successes of Quality Improvement within NHSGGC.

The module – **GGC Course 109 Quality Improvement Fundamentals** – was added to the Learnpro platform in February 2021. The formal launch of the module took place in March 2022. Between April 2022 and March 2023, 977 staff completed the module which totals 2,021 staff completing the module since it launched in February 2021. The numbers completing the module per month are displayed in Figure 5.1.

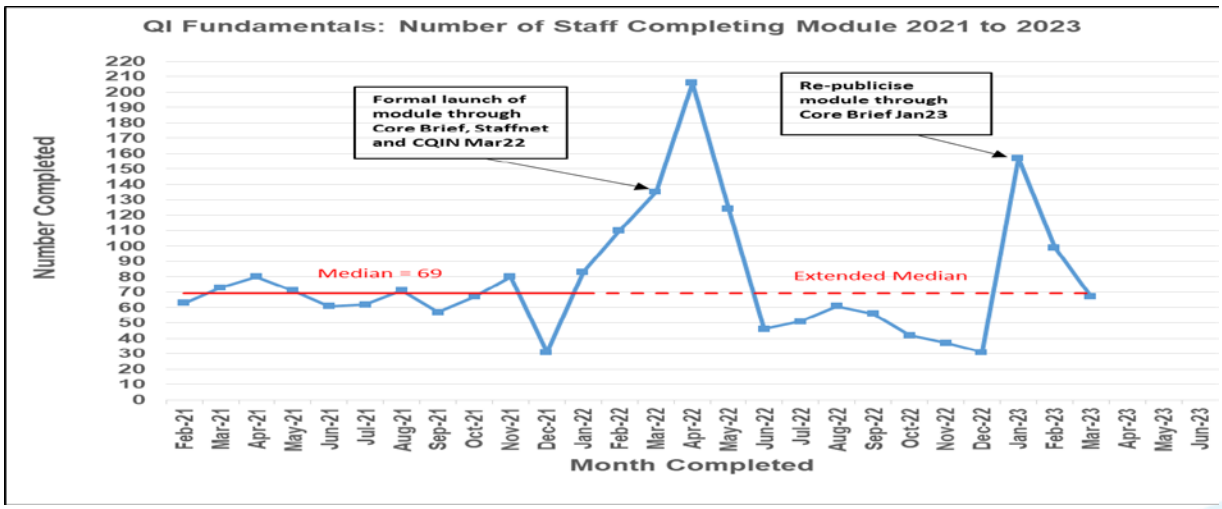
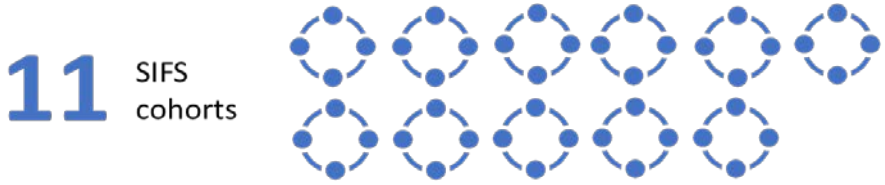


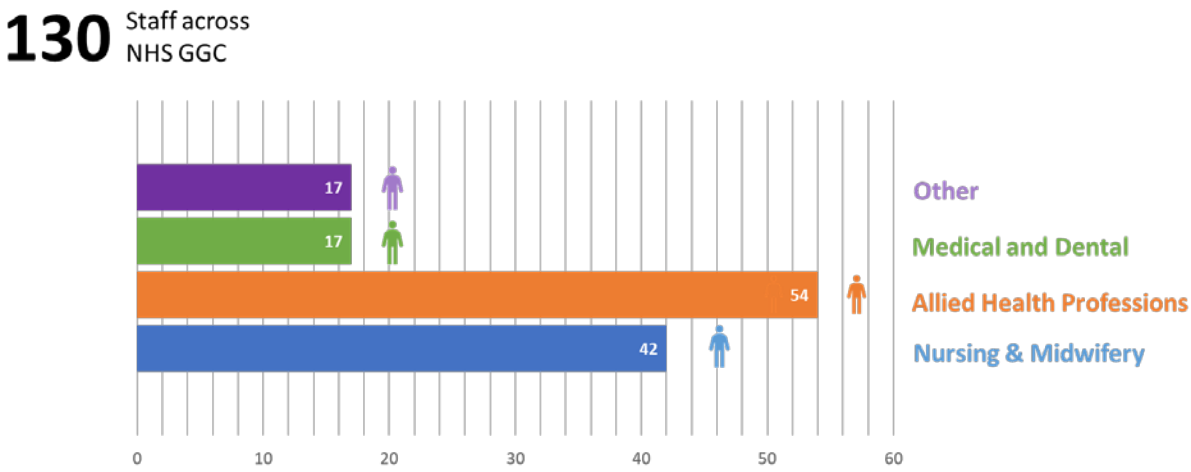

*Figure 5.1: QI Fundamentals: Number of Staff Completing Module (Feb 21 to Jun 23)*

**Scottish Improvement Foundation Skills (SIFS) Programme**

NHSGGC currently provides structured QI training through the Scottish Improvement Foundation Skills (SIFS) programme. This was developed by NHS Education Scotland (NES) 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 project teams and contribute to testing, measuring and reporting on changes made in their local clinical settings.

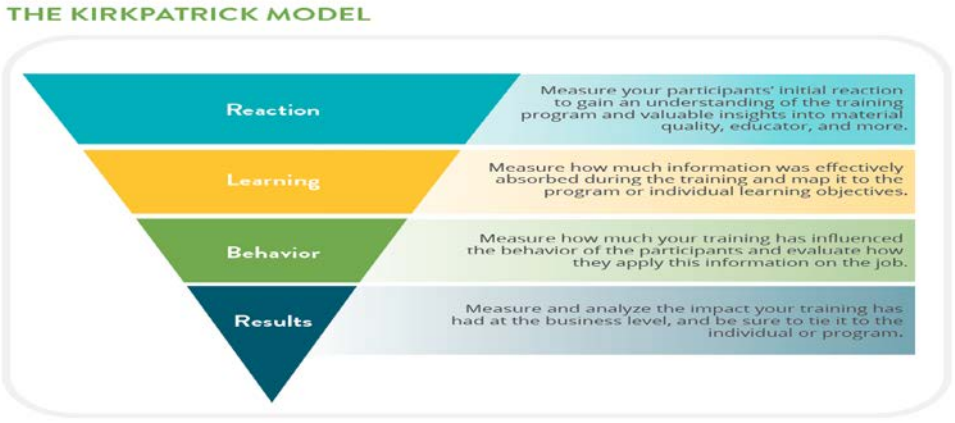
From April 2022 to March 2023, 11 cohorts totalling 130 staff across NHSGGC completed the programme.




## 5.2.4 Return of Investment

A Return of Investment process is in place for all staff completing the SIFS programme to formally evaluate this programme. This process will be using Kirkpatrick's 4 level model:



**Reaction**

**97%** of delegates who completed the programme stated they would apply their learning to their role

**100%** of delegates who completed the programme agreed that the programme content provided them with knowledge and skills to be able to make changes to their day to day work.

**Learning**

Completing the SIFS programme has consistently increased delegate knowledge around the 15 key improvement skills from
Score 2 (I know what it is) to Score 4 (I know how, when and where to use it),

**Behaviour**

Every delegate undertakes an improvement project as part of the programme. Some feedback from delegates around what they do differently following completion of the programme:
"Have a framework for project work and know how to drive the work forward"
"It has made me consider the way I approach other projects at work. Thinking about user involvement and starting small. Overall I found this an excellent course"
"More analytical when looking at improving quality of care"
"I think that I think things through in a different way and look at how to achieve outcomes in a different way"

**Results**

Measuring the impact of the training on the organisation requires short semi-structured interviews to take place.
Of the six delegates who agreed to be interviewed.

- 6/6 had completed their projects resulted in demonstrable improvements
- 6/6 had presented the results of their projects to committees or events
- One had won a Clinical Excellence Award, two had posters accepted for the NHS Scotland Event,

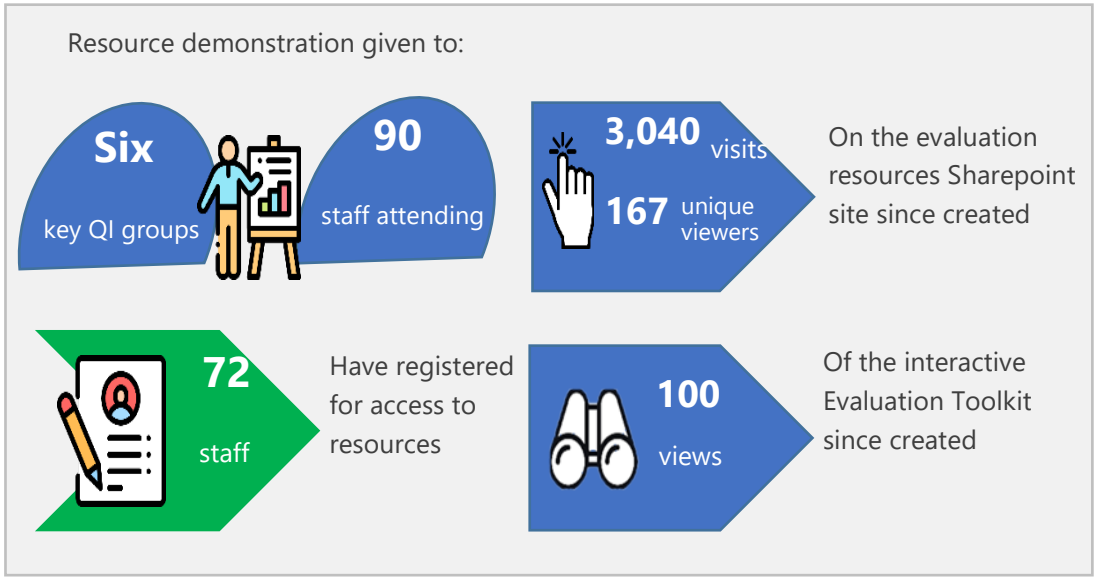
Some examples of positive impacts of the projects completed:

- Reduction in drug/ handover errors.
- Improved communication and Continuity of patient care
- Approval of an SBAR handover chart to use in theatre recovery by NHSGGC e-health record team
- Referral of patients to appropriate services
- Implementation of an advice line for staff and patients to access physiotherapy in a timely fashion.

## 5.3 Evaluation

The main focus for 2022/23 has been the finalising and launching of an evaluation toolkit for use and accompanying resources aimed at supporting staff to conduct their own evaluation work in NHSGGC. The resources have been designed to be interactive, easy to use and accessible. Alongside the resources, support and advice in evaluation is offered to staff in NHSGGC.

To date there has been a soft launch of the new resources:




The next steps are to continue engagement with key groups and officially launch the resources across NHSGGC. We are collecting feedback on staff experience using the resources. Some comments on the resources are included below:

*"Lots of really useful information. Great mix of visuals. Good layout and easy to follow and find what you are looking for."*

*"Very engaging and easy to follow - I am a big visual learner so this really held my focus."*

*"I felt it was fairly easy to understand and translate over into practice."*

*"I liked the variety of learning mediums and different functions aimed and increasing capability and the possibility of collaboration."*

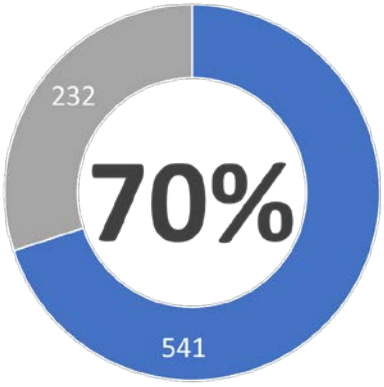
*"Clearly laid out with good examples of why evaluation is important with some useful examples of tools to use in practice."*

*"Easy to see and use. I am new to QI so very helpful"*

# 5.4 Clinical Guidelines

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

A focus this year has been to engage with those areas with clinical guidelines that have gone beyond an agreed date without review.




OF CLINICAL GUIDELINES REMAINED CURRENT AND VALID AS AT 31ST MARCH 2023

Those areas with breached clinical guidelines have been proactively addressing this through additional specialist resource; reviewing and re-energising of approving groups for clinical guidelines and the formation of working groups to review guidelines on a departmental basis. The CGSU has increased reporting on breached clinical guidelines to monitor improvement as a result of the actions put in place, with the aim of reducing the number of breached guidelines to below 5% in line with the improvement plan agreed.

At the beginning of 2022 all NHSGGC Clinical Guidelines were moved to the Right Decision Service Platform, increasing accessibility to clinical guidelines by improving the search function and enabling access from any device.

After the new platform went live, the focus was on ensuring that it was well used and met users' needs. As well as promoting the Clinical Guidelines Platform to key stakeholders such as lead authors and approving groups, the aim was to also increase the general awareness of this as a key decision support resource for clinical staff. In 2022/23 a series of roadshows in acute hospitals across NHSGGC took place, to introduce more people to the resource. QR codes were delivered to all wards, making it easy for clinical staff to have direct access to the Clinical Guidelines Platform. This awareness raising exercise was very successful, significantly increasing the total number of users of the platform by 150% from 5398 users in April 2022 to 13,503 users in March 2023.

## 5.5 Clinical Quality Publications

NHSGGC have defined Clinical Quality Publications (CQPs) as 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 publications tracked and reviewed are:

- 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.

There were 33 publications impact assessed in line with the Framework. Table 5.2 details the type of publications identified for 2022-23.

| Type of publication | Number of publications |
|---|---|
| Publications (including audit and benchmarking reports) | 24 |
| Scottish Health Technology Group publication | 4 |
| SIGN guidelines | 2 |
| HIS standard | 3 |
| **Total** | **33** |

*Table 5.2 – Types of publications identified for 2022-23*

As part of the review of CQPs, a red flag can be applied where NHSGGC is considered to be an outlier in a standard measure or indicator and where this might constitute a risk, either clinically or to the Board's reputation. A red flag includes:

- An outlier which is >3 Standard Deviations (SD) from the mean
- Where there is agreement that an outlier/ outstanding action is considered a clinical risk
- Where an outlier/ outstanding action may constitute a risk to the reputation of NHSGGC.

A report on open red flags was expanded this year to provide more oversight and assurance. A high-level summary position for publications (including open red flags) is reported quarterly to the divisional level Clinical Governance Forums to confirm service review and next steps, if required.

## 5.6 Scottish National Audit Programme (SNAP)

Public Health Scotland (PHS) publish annual national reports for selected audits/ registers which are part of the Scottish National Audit Programme (SNAP) each year. SNAP aims to ensure consistent delivery of high quality evidence based care across

Scotland reducing variation, death and disability; and ensuring patients continue to be supported to maximise their quality of life.

NHSGGC has a robust process in place for responding to SNAP. This includes ensuring ongoing data collection and quality assurance, regular review of audit data within the clinical teams and excellent engagement and response from clinical teams to the annual SNAP governance process. NHSGGC receives an official alert of any outliers within the national reports and are required to respond.

In May 2022, NHSGGC were provided with an overview of the outliers in the 2022 SNAP annual reports, which report on 2021 data. All outliers have been reviewed and responded to with ongoing progress monitored through the relevant clinical governance forums.

## 5.7 New Interventional Procedures Policy

An interventional procedure is used for treatment or diagnosis and involves incision, puncture, entry into a body cavity, electromagnetic or acoustic energy. NHSGGC New Interventional Procedures Policy sets out the approach to be taken in relation to the introduction of new interventional procedures within the Board and is designed to enable health care professionals to embrace new technologies whilst protecting patients and reducing risk. 6 new interventional procedures were registered and approved through this policy in 22/23.

- Trans Urethral Laser Ablation (TULA)
- Optilume drug coated balloon (DCB)
- Rezum: water vapour (steam therapy)
- Image-guided percutaneous laser ablation for hepatic tumours
- Endoscopic assisted correction of Craniosynostosis
- Insides System for chime recycling

## 5.8 Hospitalised Standardised Mortality Ratio

Public Health Scotland (PHS) provides information on Hospital Standardised Mortality Ratios (HSMRs). These statistics are updated on a quarterly basis and reflect the HSMR for the latest 12-month reporting period when drawing comparisons against the Scottish average.

NHSGGC has a robust process in place for responding to HSMR and has maintained a HSMR monitoring process within our clinical governance arrangements. There are two overall aims of this process. Firstly, to seek assurance that noteworthy patterns in hospital mortality data are given due attention and acted upon by our services. Secondly, to create the conditions where HSMR (and other survival data) is being used to positively develop the quality of care. There is regular reporting on HSMR through out key clincial governance groups and where relevant programmes of work are underway to review and respond to mortality data. Throughout 2022-2023 all the hospital sites in NHSGGC are within control limits in the funnel plot by hospitals for HSMR.

## 5.9 Spotlight on Innovation and Improvement

The following is a summary of some examples of improvement work and innovations which were completed during the course of 2022-2023.

### Spotlight on Innovation and Improvement

**Mental Health**

**Mental Health Services (MHS) Inpatient Incident Review**

This was commissioned to review all serious incidents (and associated recurring themes) occurring within MHS inpatient services, or where Mental Health Assessment Units had had direct involvement, within the previous 5 year period from January 2022. This followed a cluster of incidents in late summer 2021.

This comprehensive review was completed in 2022 with its findings and 13 recommendations presented at the MHS Clinical Governance Group (MHSCGG) in August 2022 and subsequently at the Board CGF. While it gave reassurance that the rate of attempted/completed suicide in inpatient settings was not increasing, it evidenced that other incident types had increased, either steadily over a number of years or associated with the pandemic pressures. It also highlighted that staff awareness of key policies was sometimes lacking and that there were inconsistencies in practice across inpatient sites regarding access/egress in open wards, grounds access at night, usage of garden areas etc. There were also recommendations in relation to supporting the SAER process in MHS, including sharing learning. A comprehensive action plan is now being taken forward through the MHSCGG and the Mental Health Policy Steering Group.

**Significant Incident Review Expert Group Learning Event**

A very successful and well-attended Significant Incident Review Expert Group (SCIREG) Learning Event was held in October 2022 at the Beardmore Hotel which 113 staff attended in person. There were speakers from HIS and MWC and sessions included: inpatient review outcomes; suicide reviews; deaths in detention; and developments in e-health in response to SAERs.

**Accreditation for Inpatient Mental Health Services (AIMS) Programme**

Specialist Learning Disability in-patient services (Claythorn, GRH and Blythswood House, Renfrewshire) excelled by achieving AIMS re-accreditation from September 2022 until May 2025.

**Mental Welfare Commission (MWC) End of Year Visit**

The MWC End of Year visit to NHSGGC took place on 9th December 2022. There was a lot of positive feedback from MWC, however areas where they identified room for improvement included:

- Emergency Detention Certificates (EDCs) and rates of MHO consent;
- Social Circumstances Report (SCR) completion rates;
- Quality of individual patient care plans.

EDC and SCR actions were taken forward through the Legislation sub-group and a very successful and well attended RMO/MHO forum meeting in early March 2023 which included representation from Primary and Acute Care. Following the event, updated local guidance for completing EDCs has been distributed, including in Acute settings. A flowchart has also been developed and added to the MyPsych and Acute Clinical apps.

The MH Quality Improvement Sub-group is overseeing work to improve the quality and individualisation of inpatient care plans, including benchmarking them against those inwards such as Jura ward (Stobhill Hospital) whose care plans were highly commended by the MWC in December 2022.

**Consent to Treatment forms**

Following a reduction in compliance with completion and accuracy of T2/T3 Consent to Treatment forms in MHS inpatient settings, a series of regular audits was implemented in 2022 with encouraging results. As well as 6-monthly Pharmacy audits, weekly Nursing audits now occur in all MHS wards with additional peer audits embedded in CCAAT. HEPMA has been updated to include T2/T3 alerts. The MH Quality Improvement Sub-group continues to monitor progress with this work.

**Alcohol Recovery Pathway and Cocaine Toolkit**

During 2022, an Alcohol Recovery Pathway, containing 10 principles of care, was produced by a multi-disciplinary group in Alcohol and Drug Recovery Services (ADRS) and approved by the Alcohol Care and Treatment Group and the ADRS Care Governance Committee. Locality-based impact assessments are underway.

Also in 2022, due to an increase in people injecting powdered cocaine, a Cocaine Toolkit has been developed to support staff on how to manage patients with cocaine use.

**Outstanding Mental Health SAERs**

Addressing the backlog of outstanding SAERs in MH continues to be a priority. Work in 2022-23 has included:

- Repeated communications to all clinical staff, Heads of Service and Professional Leads to highlight the position and direct investigators to completing any delayed SAERs as a matter of priority and/or flag up any impediments so that these can be addressed.
- Ongoing concerted efforts to identify SAE investigations that have stalled prior to completion/submission, so that issues can be clarified and completion expedited. Much of this has been done via ‘SAER surgeries’ hosted by SCIREG/Clinical Risk colleagues.

- Commissioning guidance was reviewed and staff have been reminded of the SAER policy in this regard and alternatives to SAERs for some incidents in line with the policy. It was agreed that the Mental Health guidance which supplemented the Board SAER policy would be amended to avoid confusion over the issue of a small number of incidents which do not require a SAER and so that it was fully compatible with the Board wide policy.
- Increasing the pool of investigators by extending lead investigator roles to suitably qualified non-medics; and approaching retired colleagues.
- SCIREG meeting more frequently to quality assure completed reports and close them off sooner.
- Successfully appointing to five Band 5 admin posts to support review teams with the backlog and going forward.

## Acute Services

**NHSGGC Scottish Quality and Safety Fellows and Scottish Improvement Leaders event**

An Acute Services Division Scottish Quality and Safety Fellows and Scottish Improvement Leaders event was held on the 21st April 2023, to bring QI Leaders together to provide a forum to discuss how they can be supported to utilise their improvement skills The themes identified were current QI activity, constraints and enablers.

The key constraints were

- Under-utilisation of QI Skills,
- Lack of Investment, Time and Resources in do QI

The key enablers were

- Time, resources and support,
- learning from other Health Boards,
- Development of QI Network / Building QI Capability,
- revising the approach to change / QI within NHSGGC.

Next steps are to develop a QI Network, QI Faculty and Resource Hub.

**Cauda Equina Syndrome (CES)**

A pathway for urgent imaging for suspected Cauda Equina Syndrome (CES) was developed with the purpose of providing a focus for improving the provision of imaging for suspected Cauda Equina Syndrome (CES). The pathway outlines roles and responsibilities, as well as principles for managing cases. Monitoring and review will consist of a rolling audit of patents

with suspected CES that breach the ED 4-hour target, and a rolling audit of time from presentation to imaging and then operation in the cases that are positive on MRI.

**Out Patient Antimicrobial Therapy**
The OPAT model provides opportunities to achieve further reductions in length of stay in suitable patients including earlier and wider identification of those patients who remain in hospital. There is an increasing need for early supported discharge alongside improving time from referral to review, patient training and discharge capacity. This will be supported through delivery of the following:

- Medication review prior to discharge improving time to discharge
- Increased capacity for OP review
- Increase of 20%- ID Consultant outpatient capacity
- Utilise digital prescribing to support the pathway

It is anticipated that the pathway once fully rolled out across NHSGGC in the next 2 years will:

- Deliver further efficiencies by releasing bed days - a minimum of 4,500 bed days per annum
- Avoidance of circa 250-350 IAU attendances in the first full year
- Direct antibiotic cost savings of at least £50,000

The number of bed days saved may be increased further as the model becomes fully embedded and established at each site. Impact of the model will be measured applying the following performance indicators:

- Number of patients referred
- Date from referral to discharge
- Length of OPAT and antibiotic utilisation/drug costs

## Primary Care and Community

**Incident Reporting on Datix**
Since the introduction of regular monitoring of overdue Datix the Renfrewshire Health and Social Care Partnership (HSCP) have saw a reduction from 145 to 15. With the help of regular scrutiny the HSCP have managed to sit within the boards top 3 achievers of low overdue Datix. These levels have been achieved thanks to all Services' commitment ensuring Datix are actioned timeously, using monthly reports provided as a prompt to maintain this level of completion.

**Drug-Related Deaths**

Drug-Related Death report from July 2022 noted 50 drug-related deaths in Renfrewshire in 2021, a decrease of 25% compared with the previous year. The Drug Death Prevention Group has been fundamental in implementing a multiagency Naloxone Delivery Group and work plan and the development of an enhanced drug death review process for Renfrewshire.

**Primary Care Quality Improvement Event**
A board wide Primary Care QI Event 'Reflect, Reset and Remobilise' was held in 2023 with all 250 practices across NHSGGC invited. A showcase of QI projects from clusters across HSCPS was shared as well as guidance for teams accessing support with data and QI training.

**Confirmation of Death (CoD) Policy**
Replacing the previous Verification of Expected Death (VoED) policy, this policy formalises a Chief Nursing Officer directive from May 2017 indicating any trained healthcare professional could verify death in all circumstances. NES have led the development of national supporting education documents and resources and locally these have been implemented by a Chief Nurse and a Nurse Consultant. The policy also removes the need for a VoED form to be in place signed by a medical practitioner as was the case previously

**Glasgow City HSCP Joint Inspection of Adult Support & Protection (ASP)**
A joint inspection by the Care Inspectorate, Healthcare Improvement Scotland and HM Inspector of Constabulary in Scotland into ASP leadership and processes reported in October. This concluded "the partnership's strategic leadership for adult support and protection was very effective and demonstrated major strengths supporting positive experiences and outcomes for adults at risk of harm". It also found that "the partnership's key processes for adult support and protection were effective with areas for improvement. There were clear strengths supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement".
An event was held at Hampden on 2nd November where the lead inspector highlighted areas of good practice. A series of events to share the findings with staff have been planned.

## Developing a Digital Solution for Nursing Documentation
## Shona Thomson, Practice Development Nurse NHSGGC

Digital Clinical Notes (DCN) is a new digital solution which will replace paper clinical notes across nine acute hospital sites in the largest Health Board in the United Kingdom; NHS Greater Glasgow and Clyde (NHSGGC), in an organisation-wide phased implementation of multi-professional documentation onto a digital platform.

Accurate, high quality multi-disciplinary nursing documentation is vital to person- centred, safe, effective patient care. Ward care audits observed high quality care delivery and practice which is not consistently reflected in the patient's documentation and care plans.

This variable completion of paper nursing documentation, including mandatory risk assessments, afforded an exciting opportunity to investigate and develop the transfer of paper documentation onto the digital platform. This was undertaken using a collaborative QI approach involving Practice Development, eHealth and the person- centred care team, influencing the design, improving content, flow and layout of the dynamic digital solution.

Most importantly there was an opportunity to reinvigorate the person-centred, effective and safe care approach to the nursing process which is one of the key quality ambitions in the Quality Strategy.

Strategy for Change

- Process mapping examined current nursing admission & assessment pathways, including clinical risk assessments and how this is used to determine the plan of care
- Benchmarking all current paper documentation to evidence based best practice care
- Subject expert and patient engagement, including structured interviews with particular emphasis on patients with protected characteristics
- Workshops to capture feedback about current documentation with the opportunity to influence digital content development
- Scrutiny of the early digital documentation drafts to remove repetition, improve clarity, clinical accuracy and promote best practice
- A structured collaborative data review process was in place between eHealth, Corporate Practice development, clinical teams and key groups

The Anticipated Benefits of DCN

- Less time documenting; releasing time to care
- The Person Centred Care Plan (PCCP) is simple, easy to use and supports the use of the Nursing Process

- A significant culture change where PCCP is pivotal to documentation of evaluated care delivery
- Quality assurance data reporting
- Forcing functions to enhance completion
- Links to best practice guidance to enhance decision making

## Use ABCD documentation to reduce incidence of avoidable pressure ulcer categorisation.

Documentation is an integral part of a registered nurse's day. The 'writing up' in a patient's notes can account for at least 10% of a nurse's time and in a 30 bedded ward this can equate to around eight hours of registered nurse time. Whilst undertaking case note reviews, as part of the process of determining why a pressure ulcer occurred, it is apparent that up to 100% of what is documented in nursing notes is ritualistic recording and not required since the information recorded is recorded elsewhere, or recording the norm, so essentially double recording for example 'medicines as charted' 'observations as charted' 'catheter patent and draining well'. However the documentation at the bedside, in particular care rounding charts are not completed adequately.

The gaps in care rounding has led to numerous hospital acquired pressure ulcers being categorised as avoidable. Since the care has not been recorded as being delivered there is also the possibility that the care has not actually been delivered leading to pressure damage.

The main goals of this project were to:

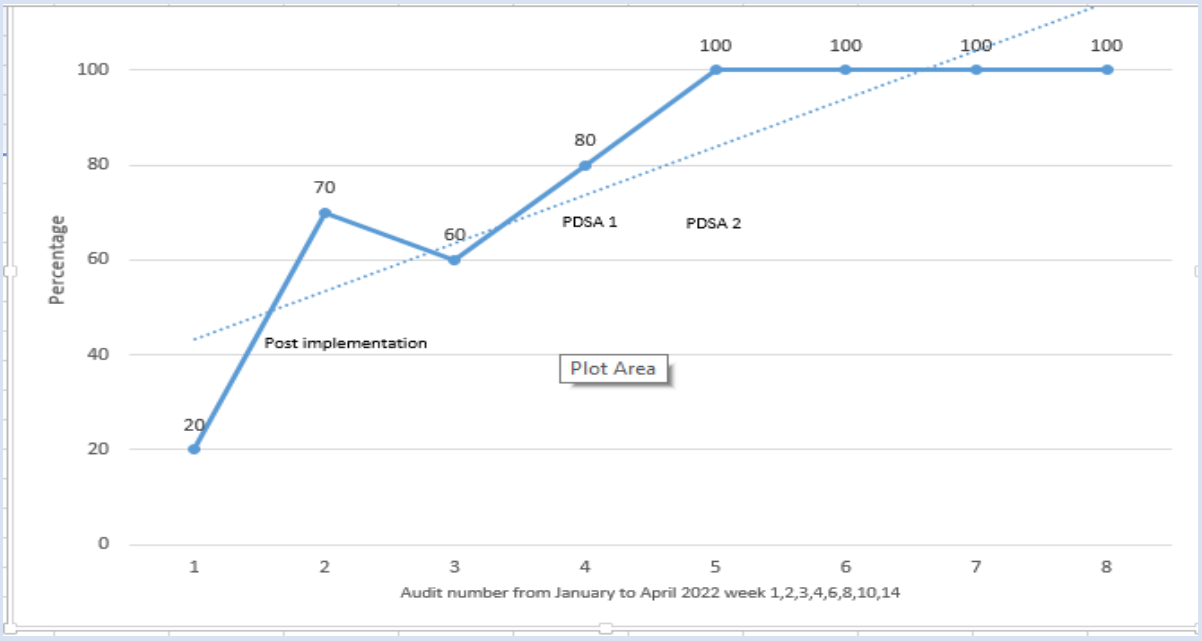
1. Stop ritualistic documentation
2. Efficient and effective use of the registered nurse's time to allow more 'hands on' care by registered nurses.
3. Good quality bedside documentation that actually reflect the care that was carried out
4. Reduction of hospital acquired pressure damage developing and/or being classified as avoidable due to incomplete documentation

The test of change aim was to achieve this by supporting nurses to undertake an ABCD approach to documentation as described below:

| | | |
|---|---|---|
| **A** | Abnormal results and observations | Only abnormal results and observations should be recorded and what has been done to address the abnormality for example – patient developed |

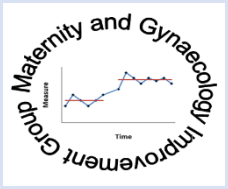
| | | |
|---|---|---|
| | | pressure ulcer on heel, referral made to podiatry. |
| B | Bedside charts | The main focus for the registered nurse is ensuring that the bedside charts are up to date and reflect the care that has been delivered on that shift, The Care Rounding Chart must be checked and any gaps in care rectified. |
| C | Essential communication | Only essential communication for the clinical team needs to be recorded. |
| D | Deviation from care plan | Only deviation from care plan needs to be recorded, but it is essential that the care plan is updated and is person centred. |

**Run chart of audit results for ABCD test of change.**



- Since this project was initiated it has been rolled out across all sectors in the Acute Services and to NHS Highland.
- It has demonstrated a positive impact on avoidable pressure ulcer incidence with wards who have this approach fully embedded reaching zero pressure ulcers.
- Ward audits have improved with wards achieving gold status for the first time and wards moving from red to green status over a four week period after initiation.
- Staff well-being has improved with nurses reporting that they are not overwhelmed by documentation and are not late off duty – to evidence this a questionnaire was sent out to 160 nurses prior to implementation to determine just how much the burden of documentation is impacting on their well-being. This will be repeated when ABCD embedded in their clinical area to ascertain if it has made a difference or not.
- The initiative won the Wounds UK Excellence award and won the silver medal at the international Journal of Wound Care Awards.

## Venous Thromboembolism in Maternity Services
## Maternity & Gynaecology Quality Improvement Group




The Maternity and Gynaecology Quality Improvement Group commissioned a key area of work focussing on the accurate completion of VTE risk assessment on Badger. Historically a paper-based form was used until the introduction of electronic Badger records facilitated the recording of VTE risk assessments. This allows all risk factors and comorbidities to be stored and viewed as well as providing a score and recommendations based on the information recorded. However, NHSGGC's weighting for some of the risk factors differ from those within Badger and some risk factors and comorbidities are electronically populated. Therefore, there remains the need for clinical judgement.

VTE risk assessments are completed at specific points during pregnancy. The area of work focused on three particular times, these being at booking appointment, 28 week appointment (+/- 3 weeks) and within 12 hours of delivery.

Using QI methodologies the antenatal and postnatal teams in all sites have been working on improving the number of women who have a risk assessment started on badger at all 3 times, the risk assessment having a response to all risk factors and comorbidities and having the VTE risk assessment verified and signed off electronically.

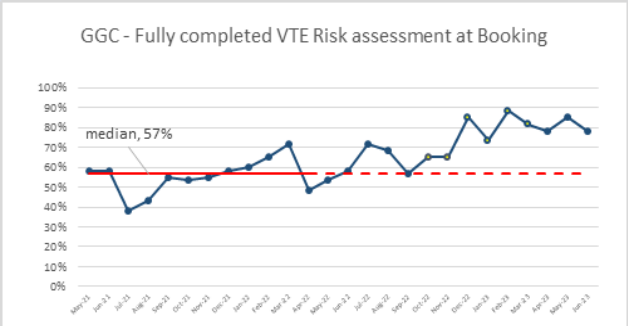



Figure 1: Percentage of fully completed risk assessment at booking

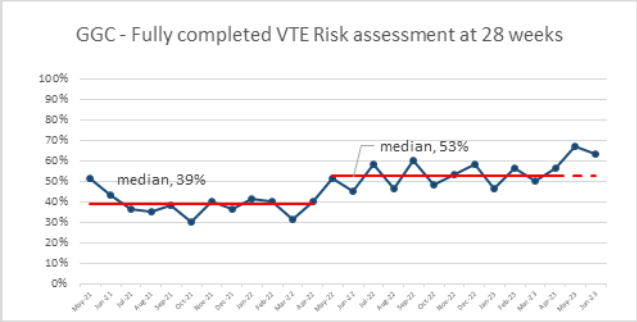



Figure 2: Percentage of fully completed risk assessment at 28 weeks

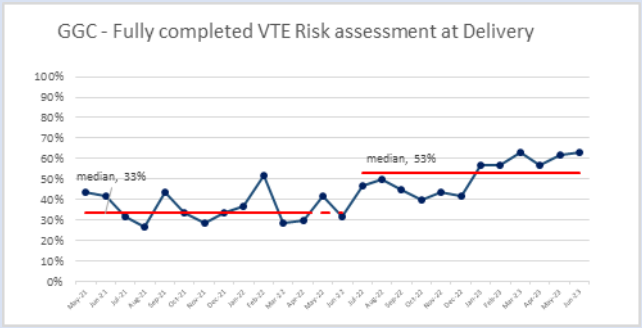



Figure 3: Percentage of fully completed risk assessment at delivery

The above charts demonstrate that at commencement of the work, the booking VTE risk assessment completion median was 57%, whilst assessments at 28 weeks and delivery had medians of 39% and 33% respectively. There is now evidence of improvement at all 3 times, with a median of 53% being achieved at both 28 week and delivery assessment.

The group will now focus its attention on maintaining and bettering this improvement and the actions following VTE risk assessment.

## Embedding Interdisciplinary In-Situ Simulation in Critical Care
Glasgow Royal Infirmary (GRI) Intensive Care Unit, NHSGGC

### Introduction
Over the last decade, research has demonstrated the positive impact of providing clinical simulation based training (SBT) to both undergraduate students and clinical staff. In situ simulation is defined as “simulations that occur in the actual clinical environment and whose participants are on-duty during their actual workday.” In situ SBT is useful for skills improvement and team development as it enables participants to experience scenarios in the clinical environment, provides a system to improve reliability and safety in high- risk areas.

### Aim
Our aim was to introduce and deliver high quality in situ SBT within our department to all members of MDT, in an attempt to improve patient care, team cohesion and develop individual’s skills and knowledge. Our vision was to create a department where SBT becomes embedded as an invaluable tool for the education and development of all members of the MDT.

### Methods
Our inter-professional simulation faculty was established in 2018. Since then, faculty members have attended various SBT workshops and completed a myriad of online competencies produced by the Clinical Skills Managed Educational Network (CSMEN) in an attempt to not only improve the quality and effectiveness of each simulation, but ensure that faculty members are appropriately qualified to maximise participants learning potential. These workshops include: designing a simulation scenario, the pre-brief and the de- brief.

As a faculty, we then began running pre- arranged simulation sessions with members of staff on shift that particular day. Topics used on these sessions included: unexpected extubation, obstructed endotracheal tube, major haemorrhage, acute desaturation, and cardiac arrest.

Following each scenario, post session feedback forms were given to participants to collate essential data in an attempt to improve future sessions and provide evidence of the effectiveness of SBT.

### Results
Following analysis of 51 post session feedback forms (100% response rate), all participants involved agreed that overall the sessions were useful and would value further in situ simulations.
100% of participants stated that their experience was a positive one, and that they would recommend participating in a future SBT session to a colleague working within the department.

### Conclusion
- Investing time in developing our inter-professional simulation faculty has given us the opportunity to provide exceptional in situ SBT to every member of our intensive care unit.

- We have demonstrated that the delivery of this type of education is safe and effective.
- All staff involved found it useful and accessible.
- Feedback suggests the impact of SBT alongside traditional competency based teaching is beneficial in achieving different educational goals.
- In-situ Simulation ideally enables a team of experts to become an expert team

Authors: M. Yates, C. Stark, J. Pawson, S. Coll, W. Clark, E. Monachello, Dr L. Paton, V. McGhee, J. Mallon, K. McGettrick, P. Bowers, Dr F. Christie

## The Long Covid Service in NHSGGC Occupational Health

Lillian Bruce, Physiotherapist; Lorraine Crothers, Occupational Therapist; Linda Fleming Occupational Health Nurse; Justine Griffin, Occupational Therapist

As a result of the COVID -19 pandemic NHSGGC had staff absent from work due to Long COVID. The staff group are closely aligned to those most likely to experience long COVID, mainly female, of working age and employed in a healthcare setting during the pandemic.

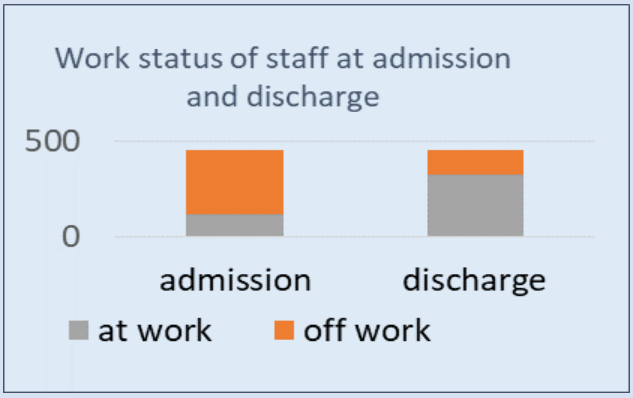
NHSGGC occupational health (OH) department secured funding over two years to develop a long COVID service for their staff absent from work due to long COVID symptoms.

The service offered the OH management referral process and rehabilitation. The remit of the team was to provide: support to staff to manage their long COVID symptoms, support staff to increase participation in meaningful activity including work, liaise with line management to facilitate employment decisions and use validated tools to measure change.

An eight week self-management group was developed to provide education and advice on symptoms management techniques to address the most commonly report symptoms (breathing pattern disorders, musculoskeletal changes, fatigue, and brain fog). The OH Occupational Health, Psychological Service and Counselling Service supported the team by delivering a group session on managing stress and worry. In addition to the group staff could access individual treatment sessions with the occupational therapists or physiotherapist. The MR report was updated as required and provided details of the employee's fitness to work and any adjustments that would support their employment and use outcome measures to measure change. The EQ5D5L, modified Fatigue Impact Scale, Dyspnoea -12 and self-rate Likert scale were used at admission, on and four months post discharge.

503 staff were referred with 454 engaging with the service over the two year project. Of these staff 85% were female the average age of staff member treated was 50. They engaged with the service on average for 280 days. 20% of staff accessed the group and

Physiotherapy and 25% the group and occupational therapy. On average, 4 individual treatment session were offered. Symptoms decreased over time, and health ratings improved. At referral 23% staff were presenting to work, and on discharge from the service 62% were presenting to work, and increase of 39% of staff at work. (94% of staff stated they would recommend the service). A four month follow up established that 48% of the staff who had returned to work felt at risk of further absences due to long covid and 42% had adjustments in place to support them at work.




Staff absent from work with symptoms of long COVID can be supported to manage their symptoms, increase their health satisfaction and return to work when supported by a self-management programme and individual rehabilitation by occupational health nurse, occupational therapy and physiotherapy. Once back at work they remain at risk of further absence due to the symptoms of long covid.

## Improving Oral Antimicrobial Treatment Course Stop Date Documentation on HEPMA

Rachael Rodger, Antimicrobial Pharmacist

### 1. Background

Documenting the planned stop date of an oral antimicrobial treatment course is important in promoting effective antimicrobial stewardship (AMS) in the acute hospital setting by helping to ensure patients receive the appropriate course length of antimicrobial therapy. In addition to improved AMS this is also important in terms of reduced patient risk, reduced cost, reduced waste, improved discharge efficiency and improved environmental sustainability. A recent meta-analysis has demonstrated that every extra day of antimicrobial therapy is associated with an increased adverse event risk to patients. In Clyde hospitals improving documentation of oral antibiotic stop dates on the prescribing chart has been an ongoing focus of AMS quality improvement (QI).

Electronic prescribing (HEPMA) was introduced to NHSGGC Clyde hospitals in early 2022. Within the antimicrobial team, introduction of this new system raised concern that oral antimicrobial stop date documentation had declined in comparison to the previous paper medicine chart system. Consequently, a QI approach was adopted at the Royal Alexandra (RAH) and Vale of Leven (VOL) hospitals to understand the current situation in terms of oral antimicrobial stop date documentation on HEPMA and set targets for improvement where required.

Initial baseline data was extracted from HEPMA from April 2022 to November 2022 for medical, surgical and older people services and stroke (OPSS) wards at RAH and VOL hospitals. In line with historical 'best in class' data the initial target set for this QI initiative is outlined below.

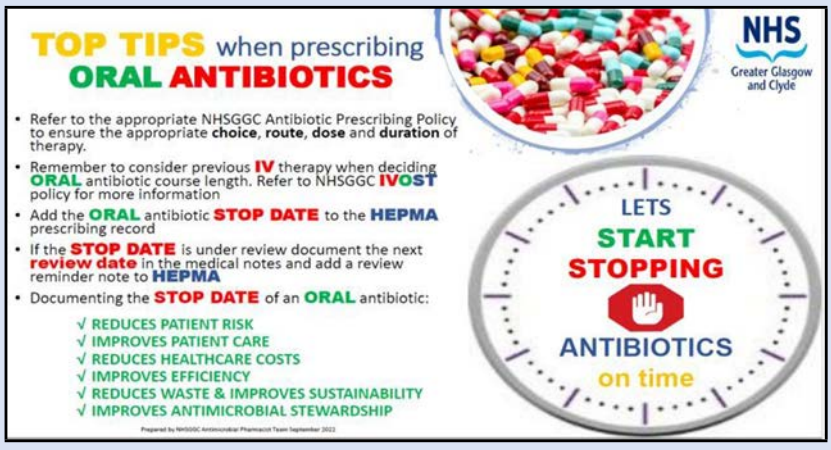
In all RAH and VOL medical, surgical and OPSS wards **75%** (median) of all **antimicrobial treatment courses** will have a planned **stop date documented** on **HEPMA** by **April 2023.**

## 2. Methods

A quality improvement approach was used across RAH and VOL hospitals to raise awareness of the importance of documenting the intended oral antibiotic stop date on HEPMA. The following 'tests of change' were used:

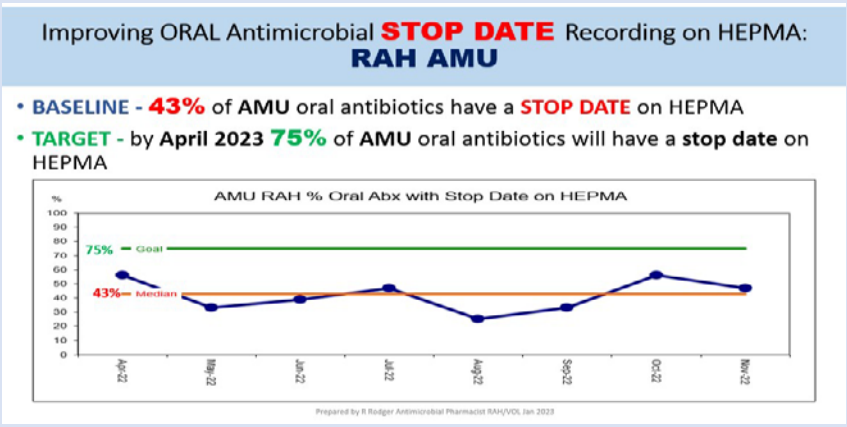
Ward posters highlighting 'Top Tips' for ensuring oral antimicrobial treatment courses are stopped on time were distributed to all wards at RAH and VOL hospitals (Figure 1). These posters also highlight the patient, staff and environmental benefits of good AMS.

Figure 1. Ward poster displays promoting oral antibiotic stop date recording on HEPMA



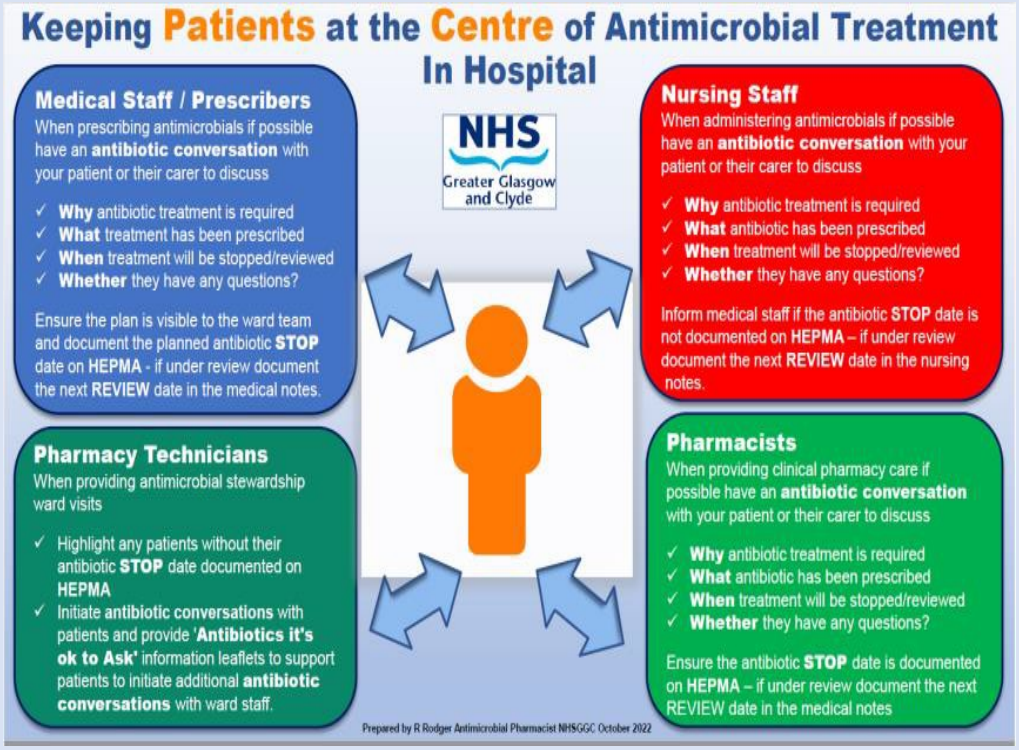

Baseline data and QI targets were shared with the multidisciplinary teams and displayed on all wards (Figure 2).

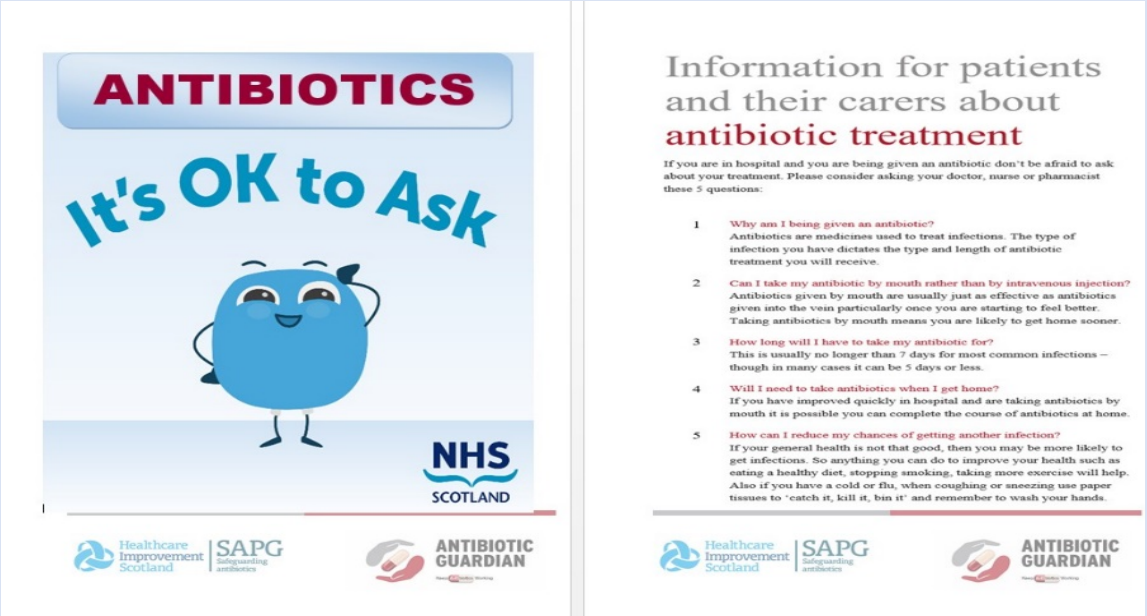
Figure 2. Ward display showing ward specific baseline data and QI target




An antimicrobial pharmacy technician (AMPT) service, adapted to the new HEPMA system, was reintroduced to RAH and VOL wards, providing prospective audit and feedback highlighting any patients on oral antimicrobial treatment courses without a HEPMA stop date. To promote patient centred care the AMPT promoted antimicrobial conversations with patients when possible and provided 'Antibiotics it's OK to ask' leaflets (Fig 3). Sticker prompts were added to medical and nursing notes to encourage addition of stop dates to HEPMA when appropriate.

Figure 3.






Data was collected monthly from HEPMA and wards with the most improved documentation of oral antibiotic stop dates highlighted. Antibiotic Gold Star awards were used to highlight and share good practice (Fig 4).

Figure 4.

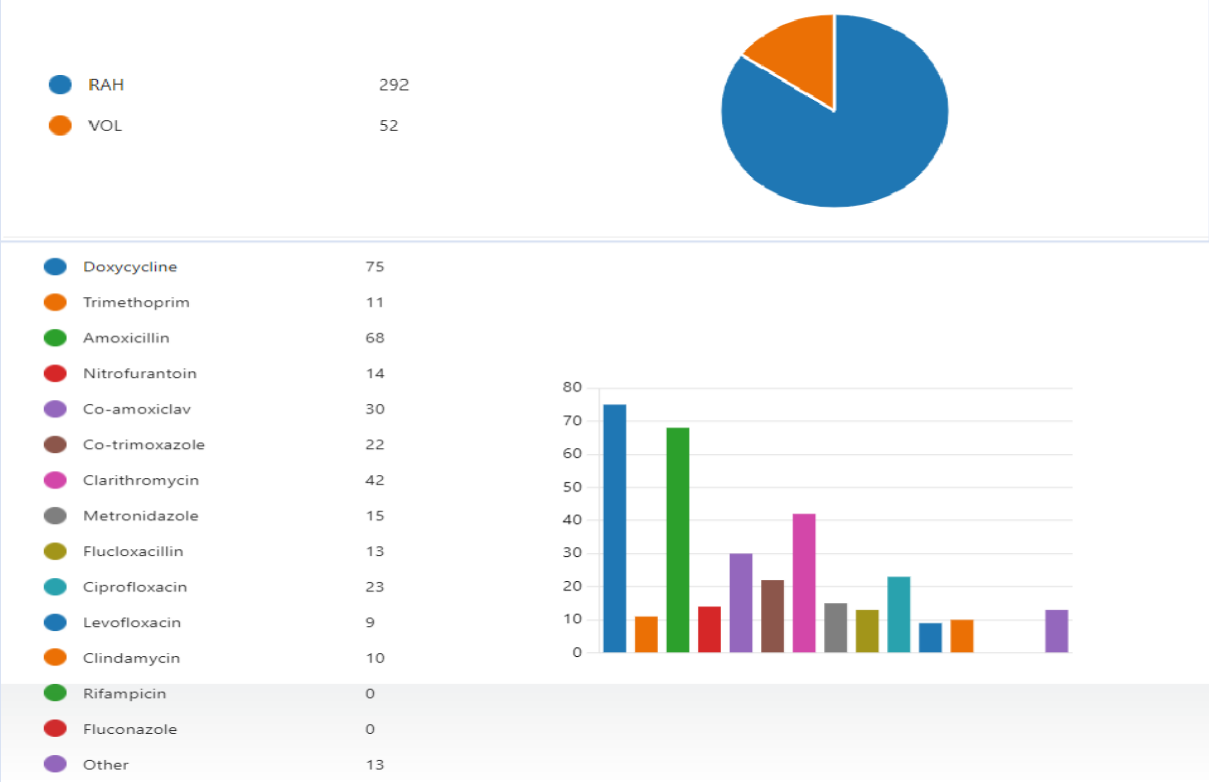
Changes were introduced to HEPMA to provide prescribing options for trimethoprim and nitrofurantoin in the treatment of urinary tract infections for male and female patients that generate an automatic stop date. A medicines update bulletin was produced and shared to

highlight this ‘test of change’.

### 3. Results

The AMPT collected data when highlighting patients on oral antibiotic treatment courses without HEPMA stop dates. Figure 5 outlines the range of antimicrobial agents without a documented stop date on HEPMA over the first six months of reintroduction of the AMPT service to RAH and VOL wards. Doxycycline, amoxicillin and clarithromycin were the most commonly encountered antimicrobials without a documented stop date

Figure 5. Oral Antimicrobial treatment courses with no stop date on HEPMA (n=344)




The results below outline data for the percentage of oral antimicrobial treatment courses with stop dates documented on HEPMA for medical, surgical and older people services and stroke (OPSS) wards at RAH and VOL hospitals. This data has been extracted monthly from HEPMA antimicrobial reports from April 2022 to April 2023 and excludes any prophylactic antimicrobial therapy. From December 2022 ‘tests of change’ as outlined above have been introduced to promote improvement in oral antimicrobial stop date recording on HEPMA.

| Result | Number of Wards (Clyde) |
|---|---|
| Met or Exceeded Target | 11 |
| Improvement demonstrated (increased median) | 13 |

| | |
|---|---|
| No improvement | 2 |
| **TOTAL** | **26** |

## 4. Discussion & Next Steps

The initial target to improve documentation of oral antibiotic stop dates on HEPMA by April 2023 was set at 75% based on historical 'best in class' results from the previous paper prescribing chart system. Following introduction of the above 'tests of change' to the RAH and VOL this target was achieved by RAH MAU, Ward 14 and Ward 27 medical wards and Ward 22, Ward 28 and Ward 15 surgical wards. RAH OPSS wards were previously collectively (wards 3,4,5,6 & 7) achieving this target at baseline and maintained the 75% target over the post 'test of change' period. These are excellent results and demonstrate the target is achievable across a range of ward specialities. The majority of other wards at RAH and VOL, although not currently meeting the 75% target, demonstrated an improvement in documentation of oral antibiotic stop dates as outlined in the graphs above. This is an excellent starting point and indicates an improved level of antimicrobial stewardship in these wards.

Data collected by the AMPT highlights the most commonly encountered oral antibiotics without documented stop dates on HEPMA at RAH are doxycycline, amoxicillin and clarithromycin. The antimicrobial team is working with the HEPMA team to consider system approaches to improve oral antibiotic stop date recording of commonly prescribed oral antimicrobials on the electronic prescribing system.

Moving forward further local 'tests of change' will be considered to improve documentation of oral antibiotic stop dates on HEPMA at both RAH and VOL hospitals. The AMPT will continue to visit wards and help prompt documentation of oral antibiotic stop dates where appropriate. Data will continue to be collected monthly from HEPMA and shared with ward teams via a report every 4-6 months to monitor improvement.

# 6. Plan for 2023-2024

The workplan for clinical governance in 2023-2024 includes the following key priorities.

## 6.1 Safe Care

- Review of the NHSGGC Policy on the Management of Significant Adverse Events
- Focus on reducing SAER delays and further development of the KPI data to demonstrate improvement in Significant Adverse Event Review delays
- Development of thematic reports through governance structures
- Evaluation of Commissioner Training
- Incident Management System Contract Renewal and Procurement
- Project Planning for Incident Management System Implementation

## 6.2 Effective Care

- Develop new Quality Improvement Capability Plan for 2023 to 2025 as part of the development of the Healthcare Quality Strategy.
- Progress the Quality Improvement Programmes for Deteriorating Patient, Falls, Perinatal, Paediatrics, Mental Health and Primary Care by engaging with clinical and management teams and identify teams to start testing and measuring change ideas to reduce harm and improve the experience of patients.
- Improving the robustness of data collection processes for cardiac arrest to support the NHSGGC Deteriorating Patient quality improvement programme.
- Plan and deliver a further 15 cohorts of the Scottish Improvement Foundation Skills programme by March 2024.
- Review of the NHSGGC Framework for Addressing Clinical Quality Publications.
- Continue to work towards reducing the number of breached clinical guidelines to below 5% of the total number of guidelines within NHSGGC.

# 7. Conclusion

As outlined in the introductory section of this report, this report presents a 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.

2023-2024 will see further work to strengthen our clinical governance arrangements and processes further, and to build on and learn from our activities during this year.