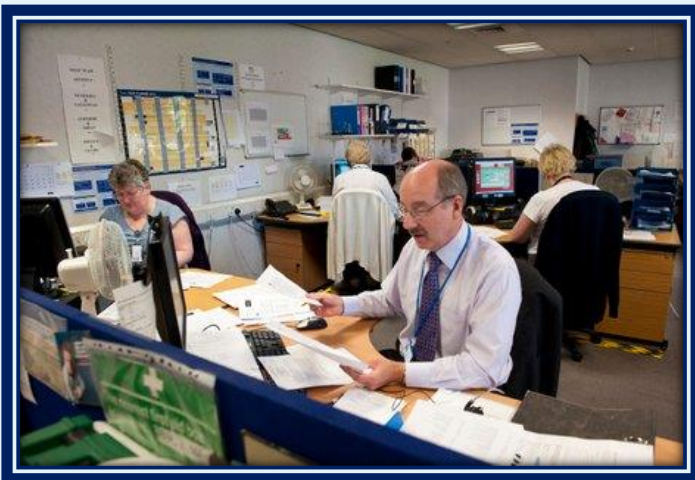


Clinical Governance Annual Report

2023-2024



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1. Introduction

Each year NHS Greater Glasgow and Clyde provides an annual clinical governance report, providing assurance that we are meeting our clinical governance obligations, and including a small selection of learning, improvement and good practice work that has taken place across the Board, recognising that there is substantially more work ongoing than can be represented in a summary annual report.

We are pleased to present the NHSGGC Clinical Governance Annual Report for 2023-2024, which 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 will be provided within the NHSGGC Quality Strategy Annual Report 2023-2024.

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.

NHS Greater Glasgow and Clyde (NHSGGC) is the largest of Scotland's 14 Health Boards and one of the largest NHS organisations in the UK



NHSGGC provides health and social care services to a population of **1.3 million people**



And employs around **41,000 staff**



We provide **strategic leadership and performance management** for the entire local NHS system to ensure services are delivered effectively and efficiently



We are responsible for provision and management of a range of health services in the area including **hospitals and General Practice**, working alongside **partnership organisations** such as **Local Authorities and the voluntary sector**.

2.2 Clinical Governance in NHS Greater Glasgow and Clyde

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

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

Our current clinical governance arrangements are outlined in figure 2.2 below, and consist of a Clinical and Care Governance Committee, established in accordance with NHS Greater Glasgow and Clyde Board Standing Orders and Scheme of Delegation; with supporting clinical governance groups.

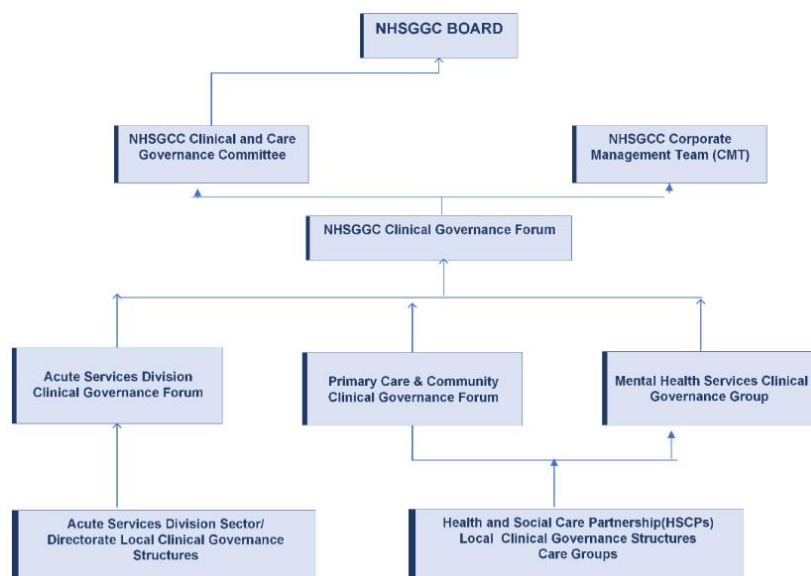


Figure 2.2: NHSGGC Clinical Governance Arrangements

2.2.1 The NHSGGC Clinical and Care Governance Committee

The Clinical and Care Governance Committee is a Standing Committee of the NHS Board. The overall purpose of the committee is to scrutinise and provide assurance to the NHS Board that clinical and care governance arrangements are effective across the whole system, in improving and monitoring the safety and quality of clinical care.

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 Polices 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 is outlined below.

2.3.1 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.

2.3.2 NHSGGC Healthcare Quality Strategy

The extant Quality Strategy has reached the end of its life cycle. The new strategy, Quality Everyone Everywhere was under development in 2023-24, and approved in June 2024. It was co-produced by people who use and work in our services, and those who matter to them. The updated strategy will identify priorities for action and provides a framework which can be used throughout the organisation in clinical and support service settings. The priorities include the overarching principle of Quality Everyone Everywhere, with 4 additional priority areas: Safe, Effective and Efficient; Person-Centred; Co-production; and learning and improving. There is work ongoing to develop an implementation plan.

2.3.3 NHSGGC Policy on the Management of Significant Adverse Events

The Policy advises on the definition of a Significant Adverse Event (SAE) and addresses the immediate action and communication following a SAE. It then focuses on the subsequent reporting, recording and review processes, including monitoring of actions.

A toolkit has been developed to support the implementation of the policy. This contains templates for all documents referred to in the policy, guides for local procedures, guidance on tools and processes, as well as key information links.

2.3.4 NHSGGC Policy and Procedure Duty of Candour Compliance

The purpose of the NHSGGC Policy and Procedure Duty of Candour Compliance is to improve the support, timeliness, quality and consistency of communication with patients and / or relevant persons when an unexpected or unintended incident occurs; and to provide clear information to staff on what they should do when they are involved in an incident and the support available to them.

2.3.5 NHSGGC Clinical Guidelines Framework

The NHSGGC Clinical Guideline Framework aims to ensure that there is a robust process in place within NHSGGC for the development, review, approval and monitoring of clinical guidelines. The framework incorporates both medicine and non- medicine related clinical guidelines. A toolkit has been developed to support the implementation of this framework, which contains guidance, and relevant templates and processes.

2.3.6 NHSGGC Clinical Quality Publications Framework

The framework aims to ensure that the Board is aware of the most recent Clinical Quality Publications (these are documents which seek to inform and assure clinical practice and processes); 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.

2.3.7 NHSGGC New Interventional Procedure Policy

The policy sets out the approach to be taken in relation to the introduction of a new interventional procedure in NHSGGC. It is designed to enable healthcare professionals to embrace new technologies while protecting patients and reducing risk. An interventional procedure is one used for treatment or diagnosis that involves incision, puncture, entry into a body cavity, or electromagnetic or acoustic energy.

3. Key Messages

Clinical governance arrangements have been maintained throughout the year.



Meetings of the Clinical and Care Governance Committee, Board, Acute, Mental Health, and Primary Care and Community Clinical Governance Groups have all continued during 2023-24.



NHSGGC has made progress against improvement aims to reduce overdue SAERS, and to review potential SAERS.



A KPI dashboard is in place to allow divisional clinical governance groups to monitor SAER KPIs



There were 22 incidents where Duty of Candour applied. Full compliance was achieved for all concluded duty of candour incidents.



A continued focus for this year has been to reduce the number of breached guidelines; that is, clinical guidelines that have gone beyond an agreed date without review. Several improvements aim have been agreed and are being progressed.



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 to the annual SNAP governance process,



NHSGGC is leading and supporting a range of quality improvement programmes across the Board.



NHSGGC is enhancing its quality capability through a range of training initiatives, a QI network, and development of a learning system.



4. Programmes of work

4:1 Clinical Governance Arrangements

Clinical Governance Meetings

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 2023-24.

Some of our key activities in 2023-2024 to progress and strengthen our clinical governance arrangements include:

- The Acute Clinical Governance Forum have 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. The Terms of Reference and Reporting Schedule have also been reviewed and approved.
- Each year the Board Clinical Governance Forum updates the terms of reference and cycle of business, receiving a range of Themed reports, and identified Service and Programme reports. A specific focus this year has been to review the agenda to create space for more focused discussion and decision making. Some of the topics considered include SAER Improvement aims and Trajectory, Gender Services, and Gynaecology Oncology.
- The Mental Health Services Clinical Governance Group have revised the timing of the Governance meeting to enable wider representation and participation from service leads on key clinical governance matters.
- The Primary Care and Community Clinical Governance Forum have reviewed the clinical governance workplan to strengthen clinical governance arrangements.

Review of key policies and frameworks

The following policies and frameworks were reviewed and updated in 2023-24:

- The NHSGGC Clinical Governance Policy was updated to replace the previous policy from June 2016. An accompanying toolkit was also launched, which provides a suite of guidance documents and templates to support Clinical Governance Forums and their Chair's.
- The NHSGGC Policy on the Management of Significant Adverse Events was approved in September 2023 and was implemented from 6th November 2023. The format of the policy was amended, and additional information was added in relation to communication with families, commissioner training, and learning summaries. The SAER toolkit was updated in line with the policy, with updated report and briefing note templates in place from 1st January 2024.
- The NHSGGC Clinical Quality Publications Framework was updated in line with its 2-year review period. Minor formatting and wording changes were made to the framework, with the list of websites tracked remaining the same. An accompanying toolkit was also created to ensure transparency around the

process of tracking, review and reporting, with further engagement work planned with services to gather feedback.

4.2 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.



4.2.1 Significant Adverse Event Reviews (SAERs)

Number of SAERs

In NHSGGC, clinical incidents are recorded through an electronic system (Datix), with a tiered approach to incident review so that the most robust investigation is 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.

Figure 4.2.1 below shows the number of Significant Adverse Event Reviews per quarter from 2014 to 2024, based on incident date. The control chart is currently statistically stable and showing normal variation. This means we are not seeing any patterns within the data in terms of the number of reviews, and we would expect the number to go up and down each quarter.

Although the chart shows a decrease in SAERs with an incident date from Q4 2022 onwards, it is acknowledged that the number of SAERs in these quarters may increase when potential SAERs are reviewed.

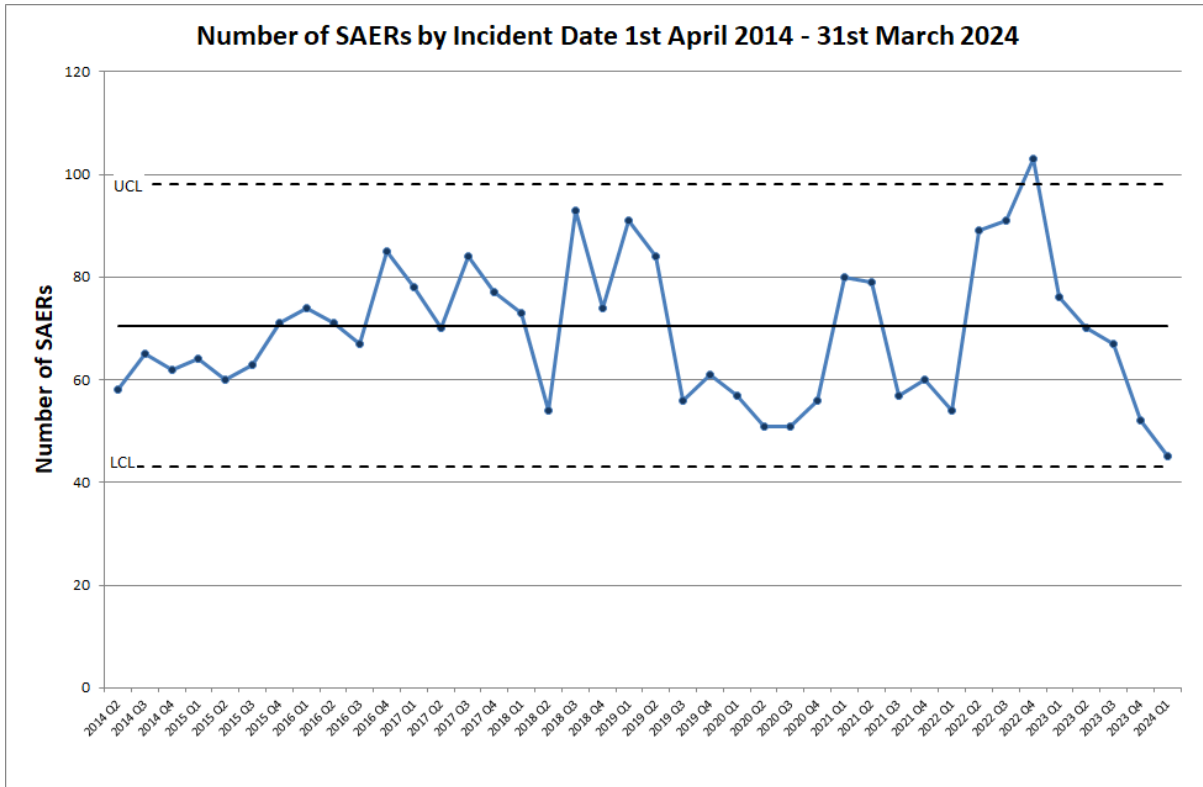


Figure 4.2.1: – Number of Significant Adverse Event Reviews per quarter from 2014 to 2024

Within the chart we can see that Q4 2022 has a point above the Upper Confidence Level. This is thought to be the result of an increased focus to review potential SAERs, with most areas showing an increase in SAERs with an incident date in this quarter, which are up around 40% compared to the 5-year median up to this point.

<h1 style="margin: 0;">292</h1> <p style="margin: 0;">SAERs commissioned in 2023/2024</p>	<h1 style="margin: 0;">44</h1>	<p style="margin: 0;">Decrease on number of SAERs commissioned 2022/23</p>
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Between April 2023 and March 2024:

- 292 SAERs were commissioned in this period (which is a decrease of 44 from 2022/23)
- 243 clinical incidents which triggered a SAER had an incident date occurring in this period.

The difference in the number can be explained by clinical incidents which are awaiting a decision to commission a SAER (for example, a SAER could be commissioned in April 2023, but the clinical incident took place in February 2023).

Commissioning of SAERs

In 2023/24, NHSGGC saw a 25% rise in the number of SAERs awaiting a commissioning decision. Each Divisional Clinical Governance Forum monitors this through monthly KPI reports with the aim of improving the time taken to make a decision. Targeted plans are in place to identify the areas with the highest number of events waiting a decision on whether to commission a SAER.

Timelines to conclude SAERs

NHSGGC has also seen an overall increase in 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.

Key Performance Indicators and Improvement Aims

Five SAE key performance indicators were agreed in December 2022 to further support reporting and monitoring of progress with the management of significant adverse events. Dashboards are now in place.

Two improvement aims were agreed at the Board Clinical Governance Forum in April 2023.

- Conclude all SAERs which have an incident date earlier than 01/01/2022 by October 2023. There were 115 open SAERs with an incident date before 1st January 2023, this reduced to 34 SAERs by the 31st March 2024
- Review potential SAERs with an incident date earlier than 01/01/2022 by August 2023. By 31st March 2024 a decision is outstanding on 27 incidents.

A piece of work was commissioned in early 2024 to learn from other Boards in NHS Scotland in relation to their policies and processes for managing SAEs. The learning from these reviews will be developed into recommendations for consideration within NHSGGC.

4.2.2 Significant Adverse Event Review Outcomes

The SAER 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. All investigations therefore conclude with one of the following investigation conclusion codes:

Investigation Conclusion Code	
<i>This is not the patient outcome</i>	
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

Table 4.2.2: Investigation Conclusion Code

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 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.

For the 301 total SAERS closed in 23/24, 37% identified issues not relating to the event, or found that the care was appropriate/ well delivered.



4.2.3 Contributory factors and thematic analysis from Significant Adverse Event Reviews

As outlined in figure 4.2.3 below, the top 3 contributory factors from SAER Reviews remain Team/Social/Communication, Task factors, and Individual factors.

Divisional Clinical Governance Groups asked to review contributory factors in SAERs and to consider if quality improvement work is required.

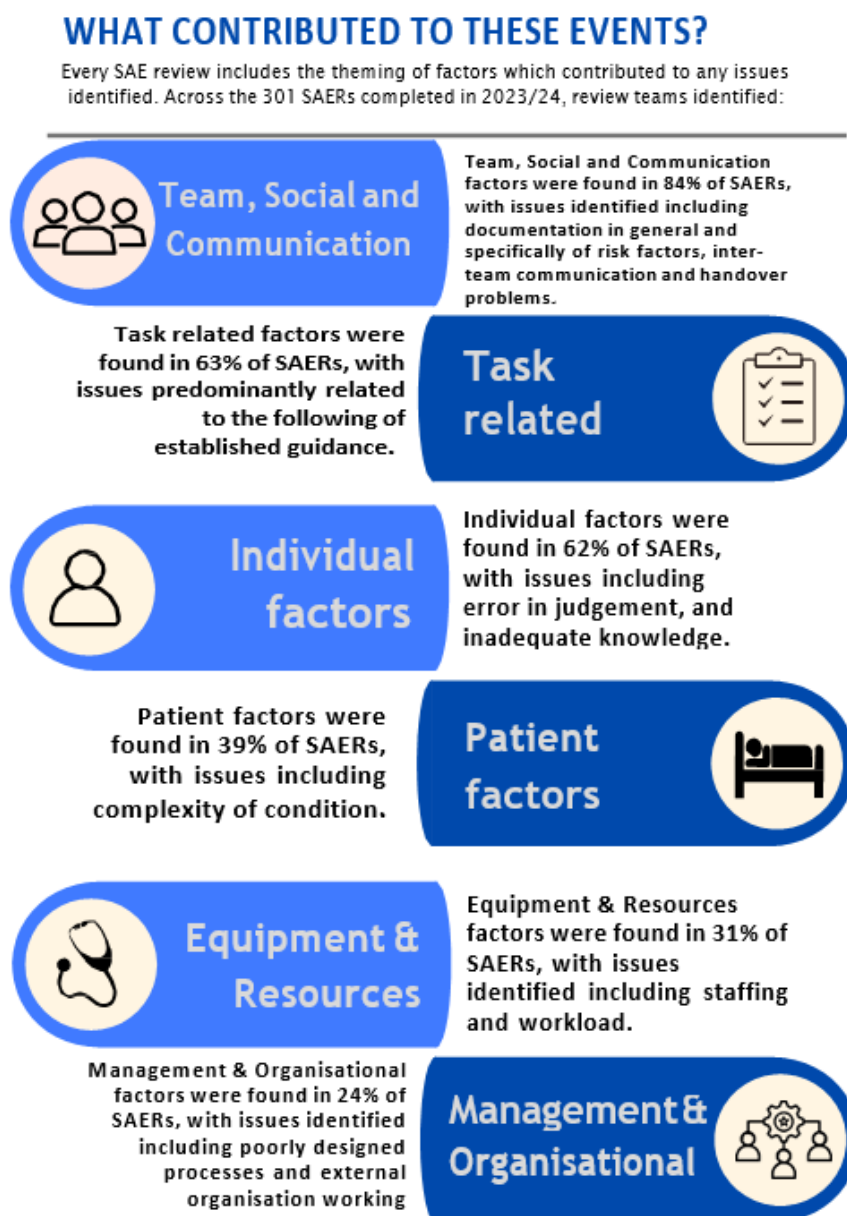
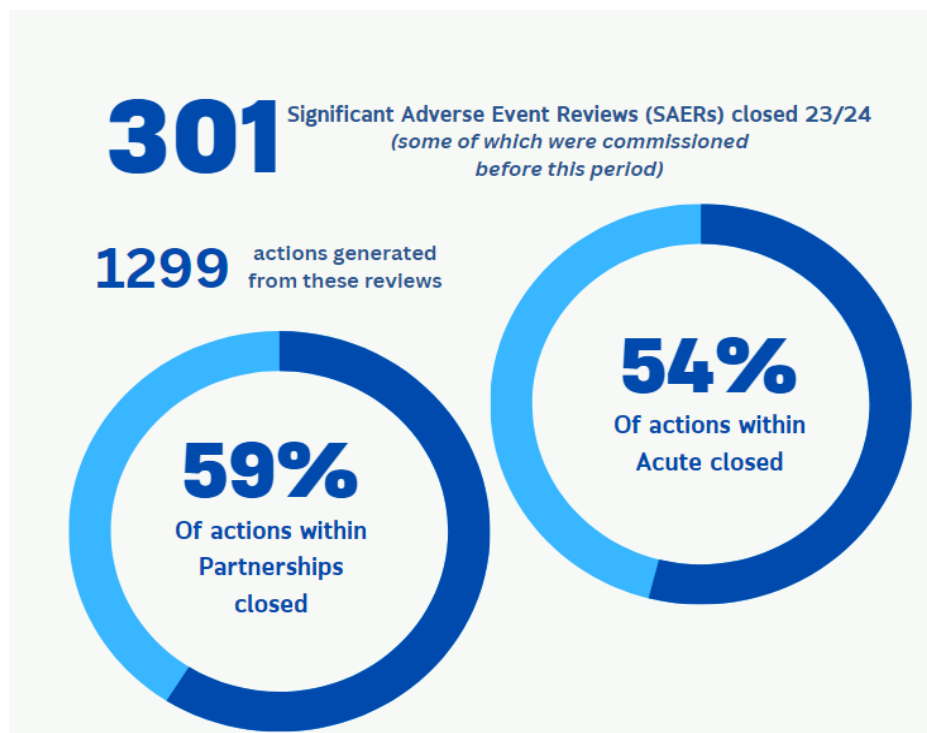


Figure 4.2.3: Contributory factors to Significant Adverse Event Reviews

4.2.4 Recommendations from SAERs



There have been a number of changes following SAERs. The list below highlights a selection of learning being applied to improve care:

- An aftercare document/summary with information for all patients being discharged from hospital with an indwelling catheter within the Emergency Department of Queen Elizabeth University Hospital. This has been developed from documents already in place within Clyde Sector. This document will also be shared with NOK/Carers where appropriate.
- The Combined Care Assurance Audit Tool (CCAAT) Peer audit commenced in September 2023 within Renfrewshire HSCP which will give assurance and governance around documentation. Staff are discussing audits and outcomes with team leads.
- The referral pathway between Alcohol and Drugs Recovery Service to Acute Addictions Service in Glasgow City HSCP – North East has been reviewed. In Glasgow City HSCP – North West the Alcohol and Drugs Recovery Service RAG Guidance and Standard Operating Procedure has been updated to reflect expectations if patient Did Not Attend (DNAs) appointments.
- An incident occurred involving a specimen leaving one hospital but was 'missing' when it was checked at a second hospital. The ED department produced a standard operating procedure document for the packaging and transfer of amputated tissue. The document was introduced into all ED within NHS GGC. Tissue must be packed for transport in a way that prevents cross contamination if

a specimen leaks. As far as possible, the tissue should be kept within a leak-proof container and be separate to the documentation on the patient and tissue type record. Tissue containers should be ordered through Procurement/PECOS. This will be supported by an information leaflet produced by the ED department for patients / relatives detailing guidance on the transport of the amputated tissue.

4.3 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.

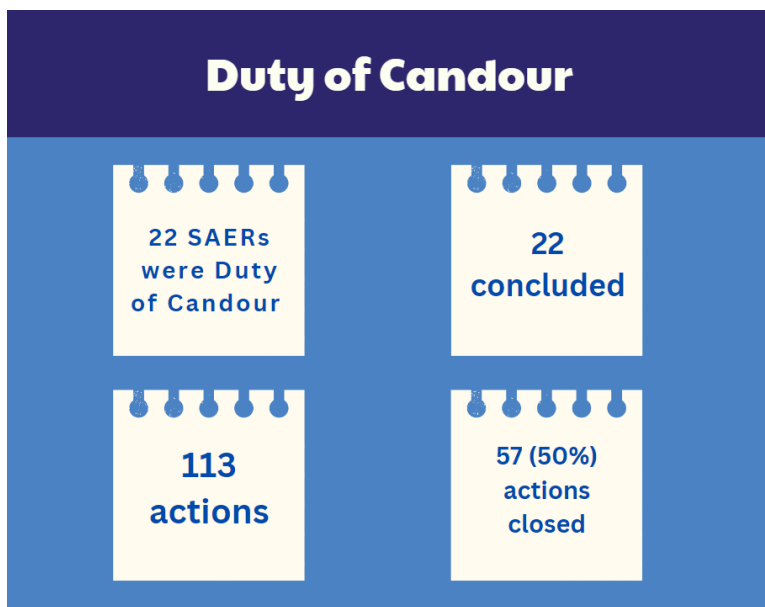
Duty of Candour means that every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes or has the potential to cause harm or distress. This means that healthcare professionals must:

- 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.

At the time of writing this report, 22 incidents were identified which triggered Duty of Candour for the period 1st April 2023 and 31st March 2024. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition.

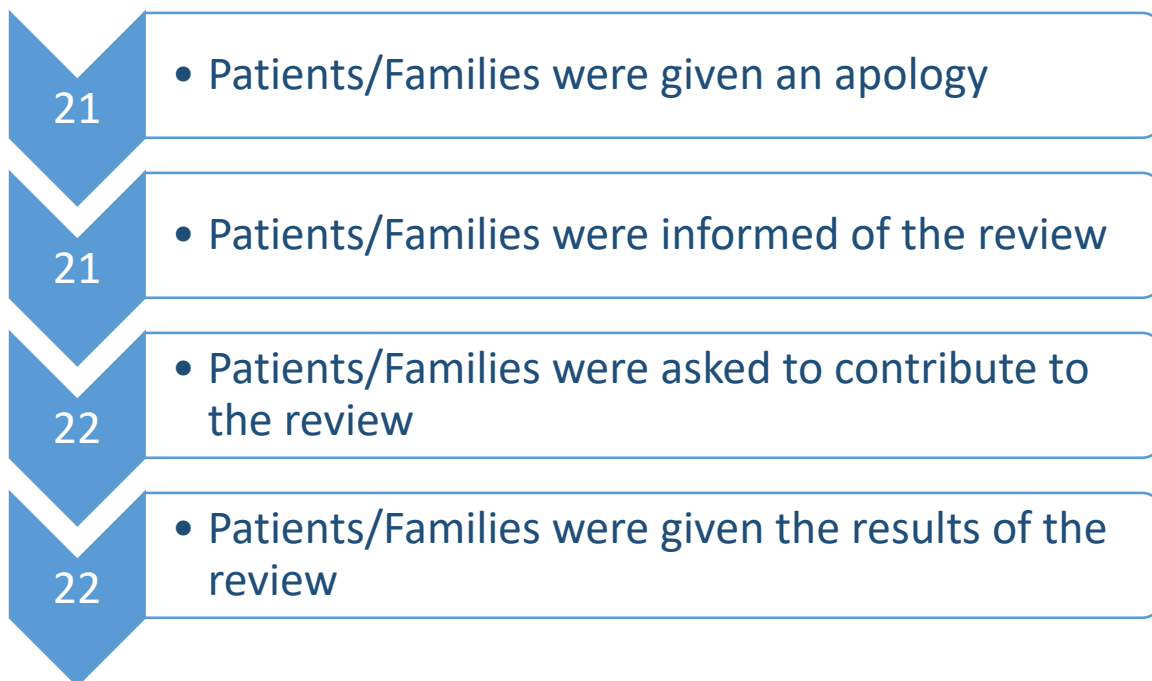


It is recognised that investigations are still ongoing when this report is produced, and until reviews are concluded, it is not possible to determine if events are duty of candour. The Duty of Candour Annual Report 2023-2024 therefore has an Addendum produced later in the year, which includes details of any additional duty of candour adverse events, and an update on those events not yet concluded.

A breakdown of the 22 incidents identified at this stage is provided below.

Type of unexpected or unintended incident	Number of times this happened
A person died	3
A person's treatment increased	16
A person's life expectancy shortened	1
The structure of a person's body changed	1
A person experienced pain or psychological harm for 28 days or more	1
Total	22

Table 4.3: Type of unexpected or unintended incident



4.3.1 Duty of Candour Update from 2022/23

As highlighted earlier, the Duty of Candour Annual Report has an Addendum produced later in the year, which includes details of any additional duty of candour adverse events identified for the reporting period, and an update on those not yet concluded when the report was written (this is due to ongoing investigations when the report is drafted).

Date	Number of Duty of Candour Event Reviews Concluded
June 2023	29
November 2023	76
June 2024	162

Table 4.4: Number of Duty of Candour Event Reviews Concluded

At the time of writing this report, the data for 2022/23 was re-run to close off this period and identified 162 DOC events overall during this period from closed SAER reports. The 162 completed investigations were assessed for compliance with the regulations, which identified:

- 155 patients/families received an apology. In 1 case disclosure would have been deemed to cause harm; in 5 cases the patient had no contact with family, or the service were unable to contact family, and in 1 case the apology was pending the SAER review.

- 155 patients/families were involved in the investigation. In 2 cases there was a clinical decision made to not involve patients/ families in the investigation; in 5 cases the patient/relative requested not to have contact or the service were unable to contact family.
- The report was shared with 150 patients/families and once again reasons for not sharing were in 2 cases disclosure would have been deemed to cause harm; in 8 cases the patient had no contact with family or the service were unable to contact family and in 2 cases the patient subsequently passed away.

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 meetings support a systematic approach to the review of healthcare, with the aim of improving patient care and providing professional learning and development.

A web-based tool, constructed on the PALS Datix module was designed to accommodate the needs of a number of specialties across the Board to keep a record of M&M meetings. The initial aim was to have 30 specialties using the electronic system by the end 2023, but this was exceeded with 35 specialties reported to be using the M&M module. A new aim to have 50 specialties using the M&M module has been agreed for the end of 2024.

4.5 Datix

4.5.1 Procurement for a new NHSGGC Risk Management System

With the current Datix system nearing end of life, a full National Procurement exercise was conducted in 2023 to identify a replacement system. NHSGGC and NHS National Services Scotland (NHSNSS), along with a number of other health boards, led a competitive tendering process which resulted in InPhase being identified as the preferred supplier. All Scottish Health Boards now have the option to use InPhase as the supplier for their risk management system.

Within NHSGGC work is ongoing to develop a business case to outline the costs, benefits and considerations associated with adopting and implementing the InPhase system.

4.5.2 Risk Registers

NHSGGC has been using the current risk management system to support robust oversight of the Corporate Risk Register. This involves aligning risks more closely with the organisational structure of NHSGCC, which in turn increases visibility and ownership for risk owners, and supports the escalation and de-escalation of risks. This work will continue through 2024.

4.5.3 Datix Data Quality Improvement

A number of Key Performance Indicators (KPIs) have been set to monitor key quality data gathered on Datix. Two key areas of focus in 2023 were:

- Reducing duplicate patient demographic records; a process for merging duplicate records is in place, which allows for more accurate reporting and analysis at individual patient level.
- Ensuring that adverse events that result in death are correctly classified; a monitoring process has been established to identify when these anomalies occur and measures put in place to flag this to the staff involved in the investigations.

4.5.4 Support to End Users

The risk systems (Datix) team provide an end user support service to staff, with almost 6000 calls being actioned in 2023-2024. These vary in nature and include maintaining access for users; setting up reports to help people understand their data; implementing system changes e.g. creating new locations and wards; providing information in response to Freedom of Information (FOI) requests; and setting up new clinical specialties on the Morbidity & Mortality module. The team also provide regular training sessions for all users via MS Teams.

4.5.5 Communication

The dedicated Datix StaffNet pages were redesigned in 2023 and the content migrated to NHSGGC's new StaffNet hub. The refreshed design provides staff with useful guidance and information on using Datix.

The bi-monthly Datix newsletter is sent to all Datix users, approximately 5000 staff. Staff are kept up to date with any changes made to the system, hints and tips on using Datix and includes key messages from the Datix Governance Group and the Board's Health & Safety Forum.

4:6 Quality Improvement Programmes



4.6.1 Scottish Patient Safety Programme (SPSP) Acute Adult Collaborative

The Scottish Patient Safety Programme (SPSP) Acute Adult Collaborative launched in September 2021 and ended in March 2024. The collaborative focused on two main areas;

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

SPSP Deteriorating Patient

The NHSGGC Deteriorating Patient Steering Group was established in January 2022, initially meeting monthly, and has been meeting bi-monthly since July 2023. The group is co-chaired by the programme Medical Lead and Nursing Lead. The group provides leadership and focuses on the four key areas of the programme within NHSGGC, 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
- working with the Realistic Medicine Network to develop an improved approach to the use and completion of Treatment Escalation Plans
- working with eHealth to develop eObservations within the Trak system.

The Steering Group provided a six-monthly report to the Acute Services Clinical Governance Forum.

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 with the final submission for the collaborative in May 2024.

NHS Greater Glasgow & Clyde
All Sites

Rate of cardiac arrests (per 1,000 discharges)

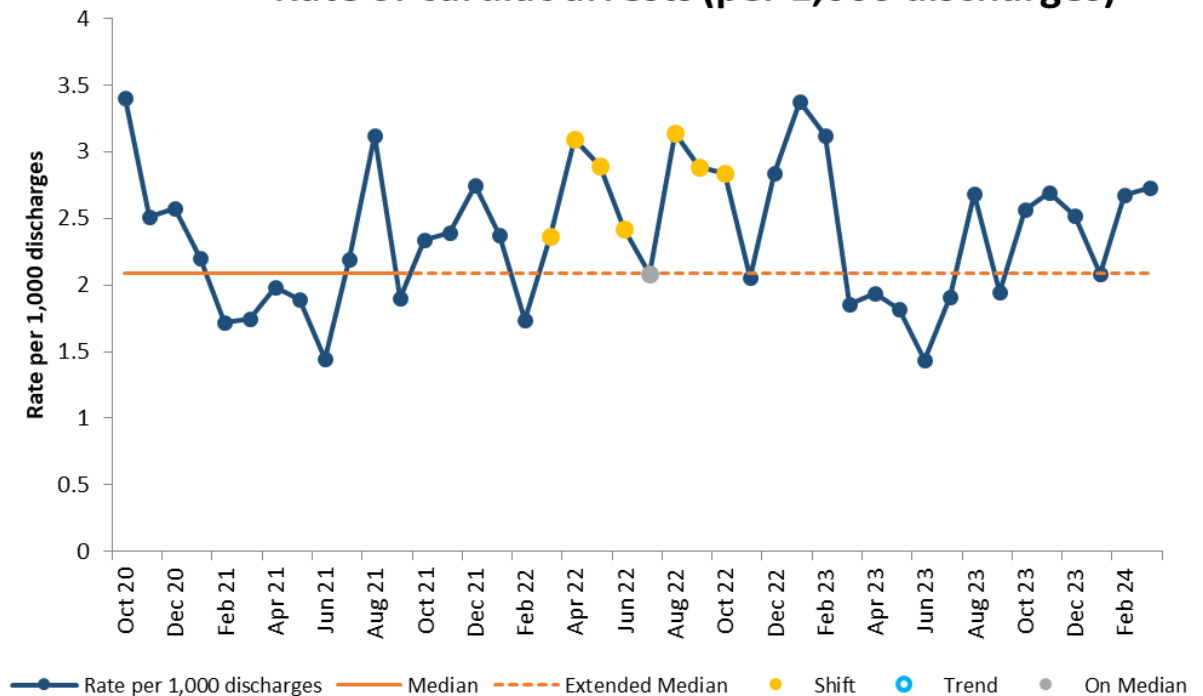


Figure 4.6.1a: NHSGGC Rate of Cardiac Arrests per 1,000 Discharges

In Figure 4.6.1a, a reduction in the rate of Cardiac Arrests was observed from February 2023 to June 2023. However, the rate has increased from July 2023.

The key successes of the Deteriorating Patient programme have been:

- Improving systems and processes around the recording of 2222 / Cardiac Arrest data. This has highlighted that we are currently over-reporting the number of cardiac arrests within NHSGGC. This work is still in progress and is expected to continue through to January 2025.
- Testing and implementing the escalation / communication boards across the Royal Alexandria Hospital site. This initiative is known as 'Who you gonna call?' and aims to provide ward staff with the appropriate contact details when a patient required to be escalated but was not requiring a crash call.
- Review and sharing of learning from cardiac arrests/crash calls on the QEUH site.
- Testing and implementing a simple visual representation of high NEWS in Medical Receiving ward in RAH.
- Structured Response mapping in Orthopaedic wards in RAH
- Data dashboards for outcome and process measures
- Providing data/charts at ward level around time between 2222 calls / days between cardiac arrests
- Safety Culture embedded in practice via Hospital Huddle identifying patients with high NEWS and concerns as well as 2222 calls identified.

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 group provides a six-monthly report to the Acute Services Clinical Governance Forum.

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 a Delphi process to establish consensus nationally.

The outcome measures for the Falls programme are:

- Reduction in Inpatient Falls rate.
- Reduction in Inpatient Falls with Harm rate.

Quarterly data submissions to Healthcare Improvement Scotland (HIS) commenced in November 2021 with the final submission for the collaborative in May 2024.

NHS Greater Glasgow & Clyde
All Sites

Inpatient Falls per 1,000 OBD

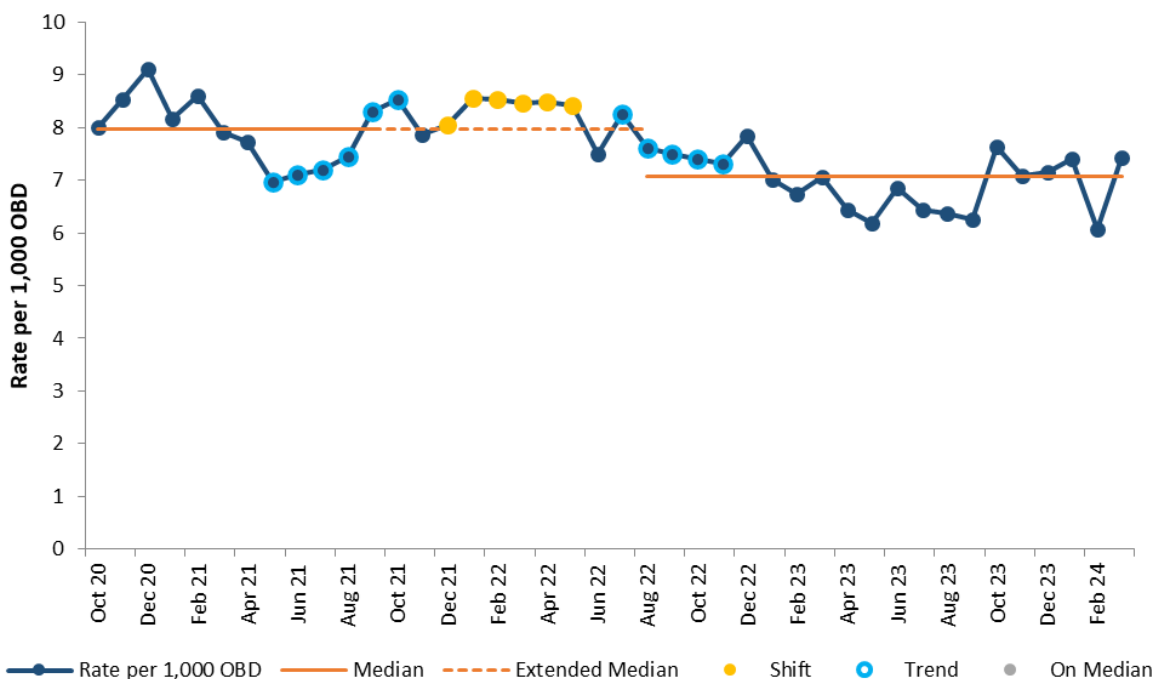


Figure 4.6.1b: NHSGGC Rate of Inpatient Falls per 1,000 Occupied Bed Days

In Figure 4.6.1b, a sustained decrease in the number of Inpatient Falls was observed from August 2022. The sustained decrease in the number of falls signalled that we could recalculate the median from its previous level of 8 falls per 1,000 OBD to 7.1 falls per 1,000 OBDs.

Inpatient Falls with Harm per 1,000 OBD

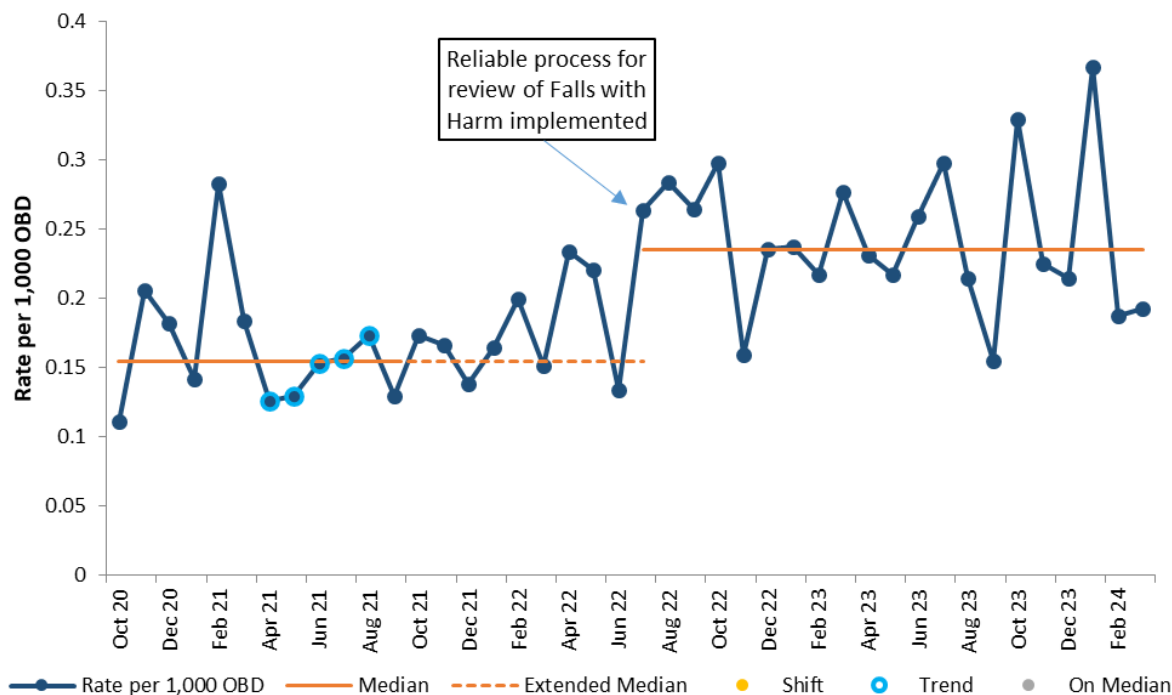


Figure 4.6.1c: NHSGGC Rate of Inpatient Falls with Harm per 1,000 Occupied Bed Days

- In Figure 4.6.1c, the rate of inpatient falls with harm was variable up to June 2022 however an upward shift was noted in July 2022 which was sustained and required the median to be recalculated from 0.15 inpatient falls with harm per 1,000 OBDs to 0.24. This increase is a result of the implementation of a more reliable system for recording falls with harm, providing more accurate data.

The key successes of the Falls programme have been:

- Introduction of Yellow Falls Visual Cues Kit
- 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 to support improved clinical care, reduction in falls and associated care needs
- New patient education leaflet which has been shared with colleagues nationally. This was coproduced with members of the Multidisciplinary Team but also with input from patients and families
- Re-focus on staff education with successful senior staff and HCSW events being held.

SPSP Paediatric Collaborative Programme

The Scottish Patient Safety Programme Paediatric Collaborative launched in September 2023. The NHSGGC Paediatrics Collaborative Steering Group was established, initially meeting in November 2023. The group are working to provide a shared vision and strategic direction for our frontline colleagues to engage in improvement work to increase safety and the healthcare experience for children, their families and staff. Quarterly data submissions to Healthcare Improvement Scotland (HIS) commenced in 2024.

The NHSGGC Paediatric Collaborative Programme's core priority is to reduce harm from deterioration by improving the prevention, recognition, response and review of the deteriorating child and young person, with the following proxy outcome measures:

- Use of correct age-related Paediatric Early Warning Score (PEWS) chart
- Reliable use of PEWS observations
- Reliable scoring of PEWS
- Reliable response to children and young people who trigger PEWS
- Unplanned admission rates to Paediatric Intensive Care Unit (PICU)
- 2222/Cardiac Arrest incidents

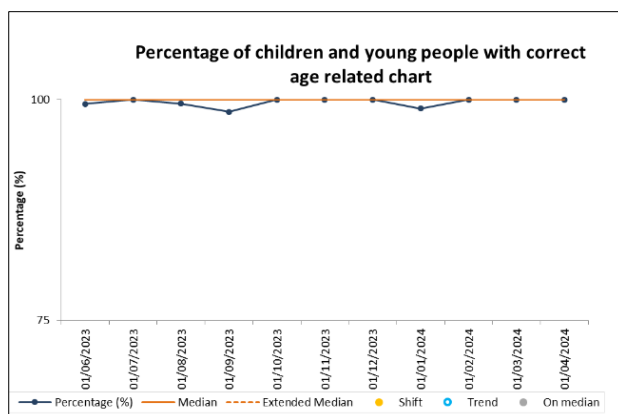


Figure 4.6.1d: Percentage of children and young correct people with correct age-related chart

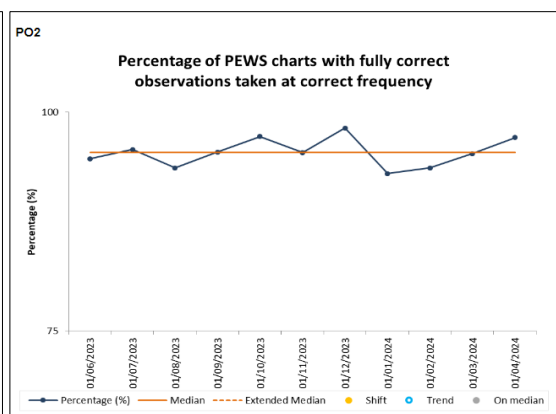


Figure 4.6.1e: Percentage of PEWS charts with observations and frequency

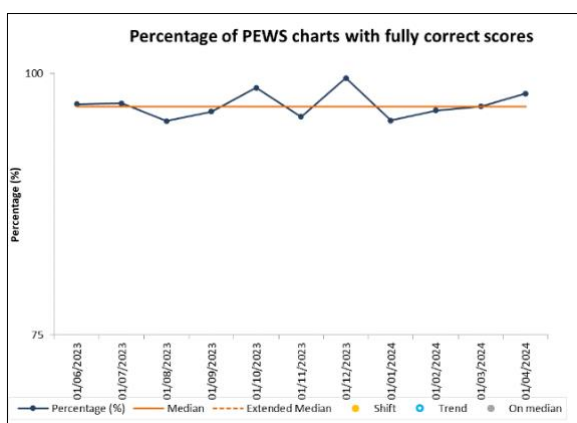


Figure 4.6.1f: Percentage of PEWS charts with fully correct scores.

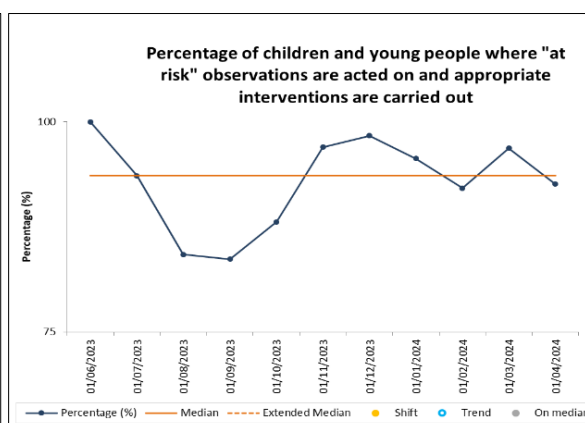


Figure 4.6.1g: Percentage of children and young people where 'at risk' observations are acted on.

To support active and confident engagement in improvement activity, a hybrid Scottish Improvement Foundation Skills course (SIFS) has been developed to promote flexible participation of sessions which enables study to take place around clinical commitments. Taking place over several months from February 2024 and encouraged for staff based in the identified test areas, this learning aims to increase knowledge, skills and confidence to apply QI methodology, enabling practical application and providing QI mentoring, thereby supporting staff to take forward work to improve safety and experience for staff, children and families.

The current projects are focused on:

- Streamlining and simplification of data collection and analysis processes to ensure safe, reliable use of data that can be easily obtained and interpreted, to make the correct, informed decisions for children, families and staff.
- Increasing the safety of administering of medicines to prevent harm.
- Accurate, effective and timely recognition, escalation and review of a deteriorating child or young person.

SPSP Perinatal Collaborative

The Scottish Patient Safety Programme Perinatal Collaborative that brings together the separate Maternity and Neonatal Programmes previously under the banner of the Maternity and Children's Quality Improvement Collaborative (MCQIC) programme, was launched in November 2023. The NHSGGC Perinatal Collaborative Steering Group was established, initially meeting on the 17th April 2024. Meeting monthly, the group are working to provide a shared vision and strategic direction for our frontline colleagues to engage in improvement work to increase safety and the healthcare experience for children, their families and staff. Quarterly data submissions to Healthcare Improvement Scotland (HIS) commenced in early 2024.

The NHSGGC Perinatal Collaborative Programme's core priorities are:

- Reduction in neonatal mortality and morbidity.
- Reduction in stillbirths
- Reduction in harm from deterioration in acute hospitals by improving the recognition, response, and review of the deteriorating woman/birthing person.
- Understanding the variation in caesarean births across GGC and Scotland. Identification of improvement priorities to work on under this programme.

The outcome measures for the four streams to this collaborative are detailed in Table 4.6.1, below. We are currently working towards identifying the current project work to be our focus for those priority aims.

Core Priority Aim	Outcome Measures
Reduce neonatal mortality and neonatal morbidity by: <ul style="list-style-type: none"> Reducing complications of prematurity Reducing late preterm and unexpected term admissions to NNU 	<ol style="list-style-type: none"> Rate of neonatal deaths Rate of preterm birth Rate: Clinical Outcomes Composite measure (NNAP) – bloodstream infection, BPD, NEC, preterm brain injury Rate of term admissions to Neonatal Unit Percentage compliance with PPWP
To reduce harm from deterioration in acute hospitals by improving the recognition, response, and review of the deteriorating woman/birthing person	<ol style="list-style-type: none"> Percentage of Maternity Early Warning Score (MEWS) charts completed, and frequency met. Percentage compliance with MEWS chart escalation pathway PPH rate – over 1.5 litre Balancing measure – number of maternity admissions to ITU
Reduction in Stillbirth	<ol style="list-style-type: none"> Rate of stillbirths
Caesarean births	<ol style="list-style-type: none"> Number of boards submitting Robson criteria data Percent completeness of Robson criteria data Number of boards using data to agree improvement priorities

Table 4.6.1: Outcome Measures

Alongside the Paediatric programme, staff working in the Perinatal programme were also offered a hybrid Scottish Improvement Foundation Skills course (SIFS).

- We are currently using data to identify areas of improvement to focus our efforts on and anticipate that this will include the following:
- Streamlining and simplification of data collection and analysis processes to ensure safe, reliable use of data that can be easily obtained and interpreted, to make the correct, informed decisions for children, families, and staff.
- Improving the recognition, response, and review of the deteriorating woman/birthing person.
- In 2023, NHSGGC's neonatal death rate was lower than the Scottish rate, and the lowest of the four other health boards used for benchmarking (NHS Grampian, NHS Lanarkshire, NHS Lothian and NHS Tayside).

4.6.2 SPSP Mental Health

SPSP Mental Health

The SPSP Mental Health Improvement Collaborative launched in April 2022 and ended in August 2023. The collaborative focused on three main areas:

- Observation to Intervention
- Restraint
- Seclusion

Two NHSGGC Adult Mental Health wards participated 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.

At the end of the national collaborative, a programme of work around Culture and Leadership was developed and commenced in January 2024. This workstream includes planned Safety Conversations and Safety Climate surveys for both staff and patients. The outputs from the surveys and safety conversations are reported into the Mental Health QI Group.

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

- Leadership of the NHSGGC Mental Health QI 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
- Commissioned work based on feedback from national inspections, standards and guidelines.

4.6.3 SPSP Primary Care Programme

Primary Care

Following a QI Remobilisation Event in May 2023 and local evaluation of Primary Care Access Programme (PCAP) experiences of Glasgow City HSCP, the strengthening of collaborative relationships aimed at building QI capability, support and networking within Primary Care and Community has been prioritised, delivery of which is guided by the driver diagram in *figure 4.6.3*,

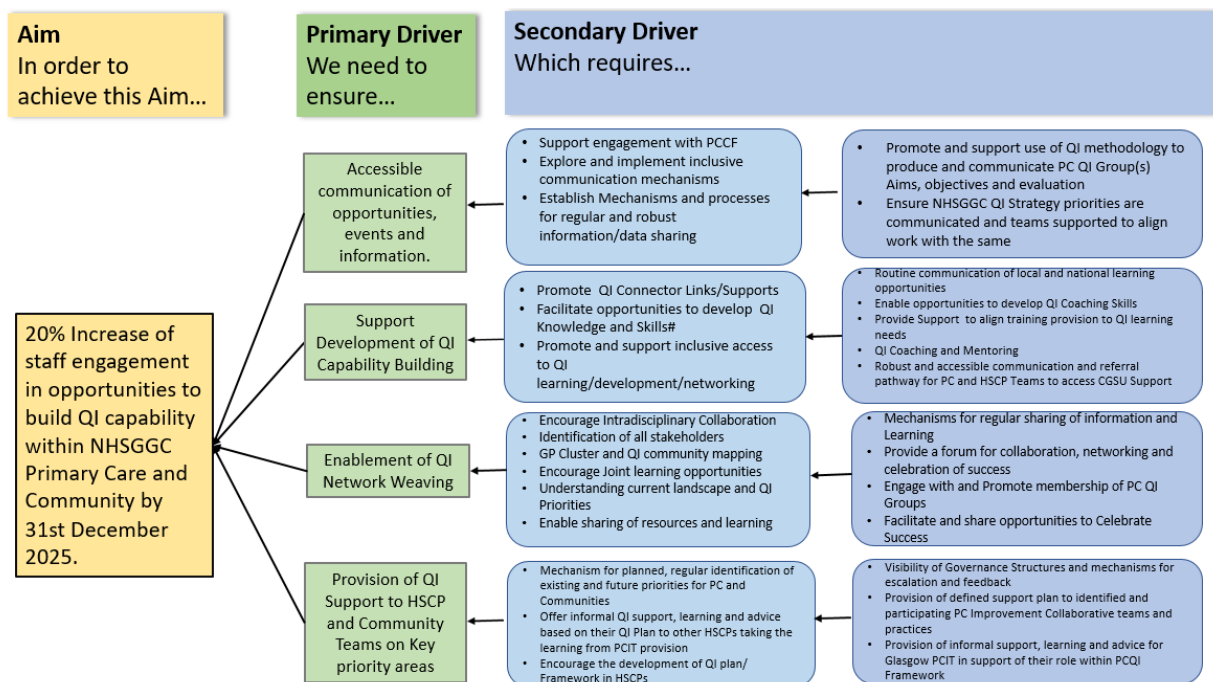


Figure 4.6.3: Driver Diagram detailing Primary Care work

The current focus is on the 4 main areas necessary to enable Primary Care and Community Services to build QI capability to undertake sustainable continuous improvement work.

- Accessible communication of opportunities, events and information
- Support development of QI capability building
- Enablement of QI Network weaving
- Provision of QI support to HSCP and community teams on key priority areas

As part of this focused effort, aligned to the Driver Diagram, a range of collaborative initiatives have commenced, and it is anticipated that further initiatives will follow over the next 3 years. Examples of these are detailed below.

Primary Care Quality Improvement Group: A key focus has been to provide support to GP Clusters and wider Primary Care multidisciplinary professionals, particularly in the approach to planning and collaboratively supporting teams to build their QI capability. Much of this work is through the Primary Care Quality Improvement group (PCQIG) which has been working on refining methods of engagement, enabling collaborative conversations and encouraging sharing and spreading of improvement successes across Primary Care and Community and Public Health.

- A QI newsletter is compiled through this group and is a means of sharing and signposting information. In addition, a Primary Care QI Repository MS Teams channel for Primary care was set up in January 2023 to streamline the sharing of resources and information.

- 4 QI workshops aimed at all Primary Care and Community staff have been delivered on the Introduction to QI methodology, QI tools, cost efficiencies and polypharmacy review and improving prescribing processes to reduce demand. The latter two sessions were designed and delivered collaboratively by pharmacy and GP teams.
- Mapping of GP Clusters across HSCPs to identify collaborators and their QI interests commenced in autumn 2023 and will be ongoing throughout 2024, having already mapped 10 cluster areas. This work supports the role of Cluster Quality Leads (CQL), development of induction packs/resources for effective cluster working and increases opportunities for sharing, collaboration and communication.
- Following on from a random sample audit undertaken on GP practice websites indicating variation within practice information and signposting for diabetes, a full audit of all practices is currently underway. Data to inform on areas of good practice and improvement will be disseminated through the PCQIG, Long Term Conditions group and Diabetes special interest groups to foster a joint approach.
- Collaboration within Primary Care and HSCPs: Working with the Primary Care Improvement Team in Glasgow City HSCP, a collaborative co-design, development and delivery of a Rapid QI Model is in development. Initially tailored to the identified needs of GP practices within Glasgow City HSCP but designed with flexibility to allow for variability, this model will be tested during summer/autumn 2024 with expectations that this will enable insight into how this could be used in localities, professions, and specialisms in other HSCPs.

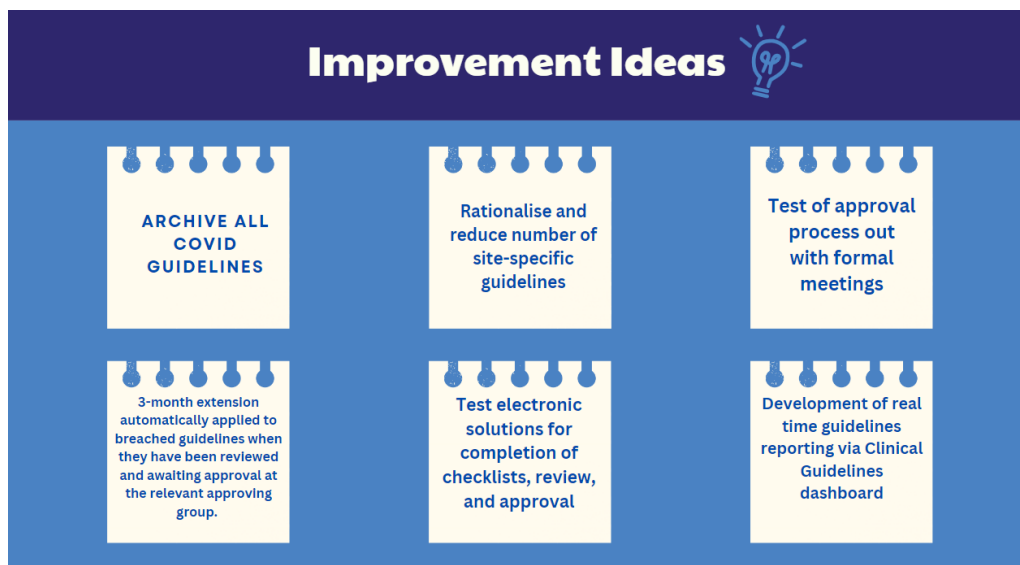
4.7 Clinical Guidelines



A continued focus for this year has been to reduce the number of breached guidelines; that is, clinical guidelines that have gone beyond an agreed date without review. As of April 2023, there were 771 clinical guidelines on the platform, 68% of

which were within their review date. Areas with the biggest backlog of breached guidelines have been proactively addressing this through additional specialist resource; reviewing and re-energising their approving groups for clinical guidelines; and putting in place 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%.

Additionally, the following improvement ideas have been progressed:



4.8 Clinical Quality Publications



NHSGGC Framework for Addressing Clinical Quality Publications aims to ensure that relevant publications are reviewed within the Board, and any actions considered. 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

The number of publications impact assessed in line with the Framework has decreased since 2022/2023, from 35 to 34 clinical quality publications. *Table 4.8* details the type of publications identified for 2023-24.

Type of publication	Number of publications
Publications (including audit and benchmarking reports)	23
Scottish Health Technology Group publication	2
SIGN guidelines	5
HIS standard	4
Total	34

Table 4.8: Publications

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

4.9 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, where NHSGGC receives an official alert of any outliers within the national reports and are required to respond.

- In May 2023, NHSGGC had 19 positive outliers, 7 outliers which required response, 9 outliers that were reviewed locally, and 6 issues noted for action. The number of positive outliers increased from 9 in 2022.
- All outliers have been reviewed and responded to, and ongoing progress is monitored through the relevant clinical governance forums.

4.10 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. 4 new interventional procedures were registered through this policy in 23/24:

- Intravascular Lithotripsy
- Water vapour (steam) therapy for treating lower urinary tract symptoms (LUTS) associated with benign prostatic hyperplasia (BPH)
- Fluorescence-guided sarcoma surgery (FGS) with indocyanine green (ICG)
- Implantation of active percutaneous bone conduction hearing implant

5. Spotlight on Innovation and Improvement

Spotlight on Innovation and Improvement



Every year we dedicate a section in the report to spotlight key innovations and improvement projects from the previous year, which highlight learning, improvement or good practice

The following is a summary of some of the work undertaken during 2023-2024.

Article 1: Mental Health

Article 2: Acute Services

Article 3: Primary Care and Community

Article 4: Focus on Frailty Glasgow Royal Infirmary

Article 5: Waiting Well for Occupational Therapy (OT)

Article 6: Food, Fluid and Nutrition Digital Resource for NHSGGC Acute Services

Article 7: Placement of dental implants using Dynamic Navigation

Article 8: Medicines Administration – A Clinical Guideline for Patient Safety

Article 9: Digital Malnutrition Universal Screening Tool (MUST) Completion within 24 Hours of Admission to Adult Neurosurgical Ward

Article 10: Empowering Patients to Self-Administer Vitamin B12 Using a Values-Based Approach

Article 11: How Early Active Mobilisation of Patients within the RAH ICU was Increased by Physiotherapy Led to Changes to Practice

Article 12: Advanced Nurse Practitioners: Initiation of First Dose Medicines During Home Visits

Article 13: NHSGGC Public Protection Strategy 2023-2024 and Policy



New Clinical Risk Management Policy

The updated MHS 07 Clinical Risk Management Policy was implemented in December 2023 with an associated new CRAFT risk assessment dynamic template on EMIS. The Policy and CRAFT have been updated to better reflect NICE and National Confidential Inquiry guidance on risk assessment, as well as findings from SAERs, emphasising a formulation and risk management approach. Updated training includes a new LearnPro module (GGC 192 Clinical Risk Management- Mental Health) and 3 yearly FTF training for all Mental Health and Social Work staff.

OPMH Falling Stars

An additional physiotherapist for Cuthbertson ward, GRH has been recruited to support this Falls initiative which is used internationally and improves staff knowledge and skills regarding falls. Since the pilot commenced in September 2023, the average falls per month has dropped from 17 to 10.

Suicide Risk and Design Group (SRDG)

Following an HSE prosecution and an intensive review of the whole Mental Health inpatient estate, the remit of this group and relevant stakeholders is to plan and oversee significant ligature risk reduction work in 10 'higher risk' Mental Health wards. This includes mitigating the impact across the system of related patient/staff movement and a small reduction in available admission beds while work is being carried out. The first ward is expected to be decanted in July/August 2024.

New Scottish Standards on ECT

The new Scottish Standards on ECT 2023 form part of the Scottish National Audit Programme (SNAP) and replace the previous Scottish ECT Accreditation Network (SEAN) Standards 2019. The new standards see the introduction of patient focussed quality improvement measures designed to promote continued positive change in patient care. These new standards will have a clinical based focus aimed at not only improving care but also improving the patient experience for those receiving ECT in Scotland.

Accreditation for Inpatient Mental Health Services (AIMS)

The Perinatal MHS Mother and Baby Unit at Leverndale Hospital was awarded RCPsych AIMS re-accreditation in August 2023.

Post Covid Hospitalisation Mental Health & Wellbeing Service

The Scottish Government agreed to implement the recommendations of the Cosette report for Mental Health After Covid Hospitalisation (MACH) services to be established in each

health board across Scotland. NHS GGC Corporate Management Team and Chief Officers agreed to use the MACH funding to develop a 'screening and brief intervention' service model, with signposting to existing services where clinically indicated. The NHS GGC MACH service was called the 'Post-Covid Hospitalisation Mental Health & Wellbeing Service' and was hosted within Specialist Mental Health Services.

The Scottish Government set several KPIs for the MACH Services across Scotland to be completed by April 2023:

- 66% of eligible individuals to be screened, assessed, and offered intervention.
- 100% to be offered assessment within 4 weeks of a positive screen.
- 75% to be offered intervention within 8 weeks of assessment if clinically required.

The service met these targets and produced a final report following completion of this work.

Most patients rated the support received as Very Good (71%) or Somewhat Good (21.4%). They indicated that the Service met their needs Very Well (55%) or Somewhat Well (35%). The self-help resources were rated as Very Useful by 63% of respondents.

The Patient Global Impressions (PGI) was completed by patients who were assessed by the service. The mean PGI score was 3.1 indicating a slight improvement after one contact. Although the service model agreed was a screen and signpost service, psychological therapy was offered for a brief period within the team where capacity allowed. Sixteen patients were offered psychological therapy and completed the CORE-10. Mean scores from pre-intervention to post-intervention decreased from 13 to 4, indicating clinically significant change. Overall, patients who were assessed by the service reported a positive experience. A small number of patients reported that the help came too late, and they needed it during the first wave of the pandemic in 2020.

Safer Drug Consumption Facility

Following a statement by Scotland's Lord Advocate on 11th September 2023, Glasgow IJB approved Glasgow HSCP's proposals to implement Safer Drug Consumption Facility (SDCF) in Hunter Street Health and Social Care Centre. Glasgow ADP and ADRS will now progress an implementation plan including development of a final Service Specification, SOPs, building renovation, staff recruitment and training, public engagement, and an evaluation. The clinical and staff governance issues will be considered and reported to appropriate HSCP and Mental Health governance forums.

Person Centred Care Programme

There is a programme of activities in development, led by Mental Health Nursing, for enhancing inpatient person-centred care. This includes:

Person Centred Care Plans in Adult Mental Health Services. This includes standards and improvements aligned to MWC recommendations being trialled prior to phased roll out across all inpatient wards in 2024 with associated training for staff and a new EMIS

template. Roll out is almost complete and feedback from the MWC to date has been positive.

Continuous Intervention Policy and Practice Guidance. Driven by national policy, this significant change to observation practice within inpatient settings is in the final stages of development and a draft policy is out for consultation. The aim is for implementation by August 2024. Multidisciplinary awareness sessions will commence at the end of May to accompany a new LearnPro module.

Wellness Tool Kit. To support person centred practice and complement Continuous Intervention, a test of change is underway for the 'wellness toolkit' (previously known as 'activity boxes') across several wards prior to full implementation.

My App: My Mental Health

This web app for patients and carers was launched in May 2023 and is on the Right Decision System platform. It is a collation of existing approved and evidence-based materials, acting as a 'one stop shop' for patients for advice, support, and self-management for a variety of mental health problems. Further promotion of the app continues.

Acute Services



GGC Diabetes Safety – December 2023

Situation: 20% of all inpatients will have diabetes; this translates to approximately 1200 inpatients across GGC at any one time.

There have been 361 Insulin related incidents reported on DATIX between January 2022 and October 2023. Of those with review complete, 13 have been coded category 4/5.

Most inpatient stays for persons with diabetes will be in non-specialist areas and because of other health conditions. GGC diabetes teams participated in NADia in 2023 (National audit of Diabetes in Inpatients); this does not demonstrate any difference in clinical activity or in diabetes related incidents in GGC compared with other Scottish health boards. The agreed approach among clinical teams in response to this audit is to focus on reducing 'never events' in inpatient stays - inpatient Diabetic ketoacidosis (DKA), Hyperosmolar hyperglycaemic state (HHS), severe hypoglycaemia and development of foot ulcers. It was confirmed that meetings have been held with clinicians from each sector, including the Diabetes MCN chair, to agree how best to reduce these risks. The education of staff is felt to be important, but in addition there are several approaches to better utilisation of existing resources being considered.

Background:

In 2018 the Diabetes MCN Inpatient subgroup reported to ACGF in response to 8 Diabetes related SAERs across GGC. Recommendations from this group were detailed but can be broadly summarised as:

1. Education

- mandate LearnPro “think, check, act” for all nursing and medical staff.
- regular messaging on insulin safety
- rolling programme of diabetes education for nursing staff
- junior doctors, especially FY1s as those largely responsible for prescribing

2. Specialist support

- relevant guidelines should be easily accessible.
- referral processes for specialist input via TrakCare

3. High risk patient identification

- proactive targeting through linking of SCI diabetes, Trak, and Libre.
- focus on coordinated discharge planning for Insulin requiring patients.

4. POC ketone testing

5. Patient empowerment to self-care

Education

SBAR to ACGF in Dec 22 ‘Think, check, act’ was supported by Chief Nurses, and is now essential training for all registered nurses across GGC. DME have also supported this SBAR and is required of all incoming FY1s as of August 2023 intake. Urology CD (North and Clyde) has mandated of all medical staff in response to SAER as of September 2023.

Education should be an ongoing exercise – Diabetes inpatient nurses can be proactive, and opportunistic but does require investment in staffing these roles, and in releasing ward staff to be educated.

Pockets of in person and online teaching across GGC are ongoing and are well received; there is enthusiasm from Diabetes MCN to deliver regular bitesize teaching. Support from Comms team would be welcome to develop this.

“Act Wisely” to be trialled in surgical receiving areas in Clyde – facilitated learning to support good decision making for FY1 doctors.

Specialist Support

GGC perioperative guidelines for Diabetes management have been approved and will be launched through GGC Grand rounds to achieve maximum visibility. Early discussion is underway with the Trak Team to support linkage of electronic capabilities to identify patients at highest risk of severe hypoglycaemia with a proactive approach taken by diabetes teams.

Monitoring

Stock-take of capability to monitor blood ketones appropriately is underway across GGC. This will require access to equipment, but also awareness of indications.

Continuous Flow Model

The Continuous Flow Model commenced on Tuesday 6 December 2022 following a prolonged period of sustained performance challenge in relation to the QEUH's unscheduled care (UCC) performance.

The model aims to share/dilute the risk that exists in all our Acute EDs and Assessment Units into the acute hospital sites, whilst at the same time supporting improvements across a range of KPIs.

In February 2024, the ACGF received a presentation providing an update on KPIs and clinical governance reviews:

- Ambulance offload times – performance improvement can be seen across all metrics in this KPI.
- Ambulance triage times – performance has remained the same at GRI and IRH, and both sites share the lowest average ambulance triage times. Both QEUH and RAH have seen improvement in this metric
- ED 12 hour waits – this is an area where all NHSGGC sites have seen considerable improvement.
- ED average length of stay – Every site has seen an improvement in this metric both overall, and from medical admissions from ED.
- Assessment unit average length of stay – All sites have seen an improvement in the length of time patients are waiting to be admitted to downstream wards from our Assessment units.
- ED 4-hour performance – All sites have seen improvement across all 4 flow groups with the exception of flow group 4 (surgical admissions) in the QEUH
- Total discharges – The total number of patients being discharged by our hospitals per week increased during 2023 versus the 3 months prior. However, the number of patients discharged before midday increased by 9%. This is a potential indicator of the Glasflow

model encouraging wards to discharge patients earlier in order to accommodate patients moved under the model.

- Discharged via Discharge Lounge – There has been a small increase in the use of the discharge lounge across the Board, driven by the 5% increase seen at QEUH. An incident review has also been completed for each site, to review any incidents that mentioned “Glasflow”, “CFM”, “Continuous” or
- “Flow”. The rate of category 4/5 incidents per week was found to be the same pre and post the model.

The next steps to support the evaluation of the model are:

- A review of complaints
- Secondary review of incidents in relation to unscheduled care by the Clinical Governance Support Unit
- Staff feedback – format to be agreed with Area partnership Forum.
- Completion of report
- Update SOP, if required

Better Visibility of Digital Clinical Safety Incidents

As part a pilot sponsored by the Healthcare Improvement Scotland (HIS) Adverse Event Network NHS Greater Glasgow and Clyde introduced a new category labelled “Healthcare IT related” incidents within the DATIX incident reporting system in March 2022. This allows staff reporting incidents to flag if they thought that IT equipment or electronic record systems were in any way implicated in the adverse event.

Following completion of the pilot in five Health Boards, the Network has now mandated this as a permanent change to Datix for all health boards from April 2024.

NHSGGC Clinical e-Health Leads review all the notified incidents, categorising for themes and affected systems. Summary reports with examples are then tabled at the relevant e-Health governance groups, such as the Digital Health and Care Records Board, e-Health clinical leadership group and operations liaison group. Incidents related to HEPMA are discussed at the HEPMA Clinical Reference Group. The analysis helps us see new and unexpected defects, and influences resource allocation and prioritisation within e-health. It does not replace the expected management of Datix by local managers, but we do pro-actively contact Datix handlers where needed to provide additional expertise. Around 70 incidents are reported monthly. Over the two years consistent themes have emerged around: gaps between EPR systems and workarounds, orders and results, patient identity and information governance.

Escalation routes include formal clinical safety notice concerns to our IT suppliers and formation of short life working groups, for example to deal with problems uncovered around letter processing in TrakCare.

The Datix incident analysis is one part of an assurance approach to digital clinical safety which builds safety thinking into design, procurement, and implementation across the whole lifecycle of systems.

For more information contact the clinical e-health leads via pmo@ggc.scot.nhs.uk

Primary Care and Community

Health Visitors: Housing & Homelessness Training with Shelter

Health Visiting (HV) Teams in Northwest Glasgow City completed a learning needs analysis in partnership with Shelter UK to consider what the specific challenges for families in relation to housing and homelessness are. This informed the content for a half day training programme in collaboration with Glasgow City housing and homelessness leads, Shelter and the Wheatly group focusing on the prevention of homelessness, support to maintain tenancies, management of damp and mould, learning re housing options and improved links for signposting for families for support with housing applications.



The feedback from HV's and skill mix staff was that they feel more confident in how to support families with housing concerns, the prevention of homeless and specifically how to escalate concerns re damp and mould which is of particular relevance following a child death in England. A test of change with a short life working group has been commenced looking at improving relationships with HV/Family Nurse Practitioners and Speech and Language Therapy.

Scottish Ambulance Service Advanced Practice Paramedic

A fixed term project with the Scottish Ambulance Service launched in Renfrewshire in April 2023 utilising Advanced Practice Paramedics to undertake appropriate GP home visits to relieve pressure on GP surgeries. 149 visits took place within the first two months with positive patient and GP Practice feedback.

Renfrewshire HSCP Enhanced Respiratory MDT

The Renfrewshire enhanced Respiratory MDT commenced a pilot with regard to COPD admission avoidance in Dec 2022. All Renfrewshire GP practices are now engaged. Initial results are very encouraging with a high number of admissions avoided. A report will be submitted to the HSCP SMT with early analysis suggested 91% of referrals resulted in an avoided admission.

MSK Physiotherapy

Waiting times have halved in the past year with the service reaching 12 weeks for routine appointment. Improvement and priority project work continues. PROMS and PREMS showing increase in function and decrease in pain post treatment.

East Renfrewshire HSCP Pharmacy Service improvement activities

Joint working between the HSCP Pharmacy team, Community Pharmacy, GP practice and nursing home team has ensured that implementation of serial prescribing has been effective and has provided early benefits in workload reduction and improved prescription management processes in one care home. Learning gained during this process will be applied to further serial prescribing implementation within East Renfrewshire Care Homes. The tools and materials developed to support the implementation in this care home will be available to support wider roll out.

Bairns Hoose East Renfrewshire

The first Bairns Hoose in Scotland has officially opened and will be used to support all child victims and witnesses of abuse. They will be interviewed and provided therapeutic intervention in this new environment, where the design team have been influenced by the children who will use it as well as from the established Icelandic 'Barnahus' model that inspired the Scottish service. Procedures around the use of the building and scheduling interviews will be developed alongside a multiagency working document on the journey of the child through Bairns Hoose. Health resources are to be further explored and developed as appropriate. Children will feel less scared during legal proceedings through the use of recorded evidence rather than the child needing to attend Court; the child and family will have all their needs in relation to the abuse incident dealt with under one roof. The House has been built in a trauma informed way to reassure children and their families. An application to be a Pathfinder area has been submitted to the Scottish Government and funding has been agreed. North Strathclyde Partnership will then be in pilot phase for 2 years, leading onto further learning and implementation in other sites across Scotland. Current use of the Bairns Hoose is fed back through the national team, who will share learning nationally.

Renfrewshire Home First Response Service

Home First Response Service continues to establish protocols and pathway across acute and partnership. Positive outcomes have been achieved for patients. The team continue to assess individuals for frailty at the front door aiming to support their discharge either directly from ED or within 3 days of admission. This is only possible by the community arm of the HFRS continuing the rehab and assessment of the individual in their home.

Since inception the service have assessed 506 patients and have been able to support 58% home either directly from ED or within 3 days of admission. Recent work has seen the RAH team become integral within the older people's assessment unit, recognising rehab opportunities and working with the substantive team to recognise and support opportunities for an earlier discharge home.

Call Before You Convey Pilot for Care Homes

This pathway is being set up as a pilot to support collaborative decision making via professional to-professional advice and escalation routes for care homes to support them with care for residents with palliative needs who may be approaching end of life.

In Renfrewshire, the Care Home Advanced Nurse Practitioner (ANP) service, in conjunction with the District Nursing ANPs, is offering support to the residential care homes within Renfrewshire HSCP over a 7-day period. This will enable residents to receive support to remain within their homely environment and reduce unnecessary conveyance to hospital for a specified range of conditions:

- residents with palliative care needs on a District Nursing Caseload
- respiratory infection
- UTI and cellulitis.

The service has had 209 consultations in December 2023, with 108 residents being maintained within their care home setting.

The Inverclyde HSCP pilot for care home residents is a single point of access telephone line to the community nursing team for advice, support, and information available to care homes. An additional nurse will be on duty with the community team and an Advanced Nurse Practitioner is on call to support any calls or visits as required.

A virtual ward meeting is being held at the end of every week with all relevant staff in attendance and care homes attending as required if they have a resident who they have concerns about. This facilitates a proactive approach, advanced planning, and coordination of care.

Work is underway to connect with the Scottish Ambulance Service Macmillan End of Life pilot as part of this work to ensure if ambulances are called and feel that a resident does not require admission, the paramedic crew can contact the service to gain support for the resident and the care home from the local team.

Outcomes of the project will be reported via the Unscheduled Care group locally and NHSGGC wide. Ardgowan Hospice on-call team will provide an additional level of specialist palliative care support as required and will be offering palliative and end of life training to every care home, on site in the individual homes over the winter period.

Care Home Assurance Team – SPAR project in Glasgow City

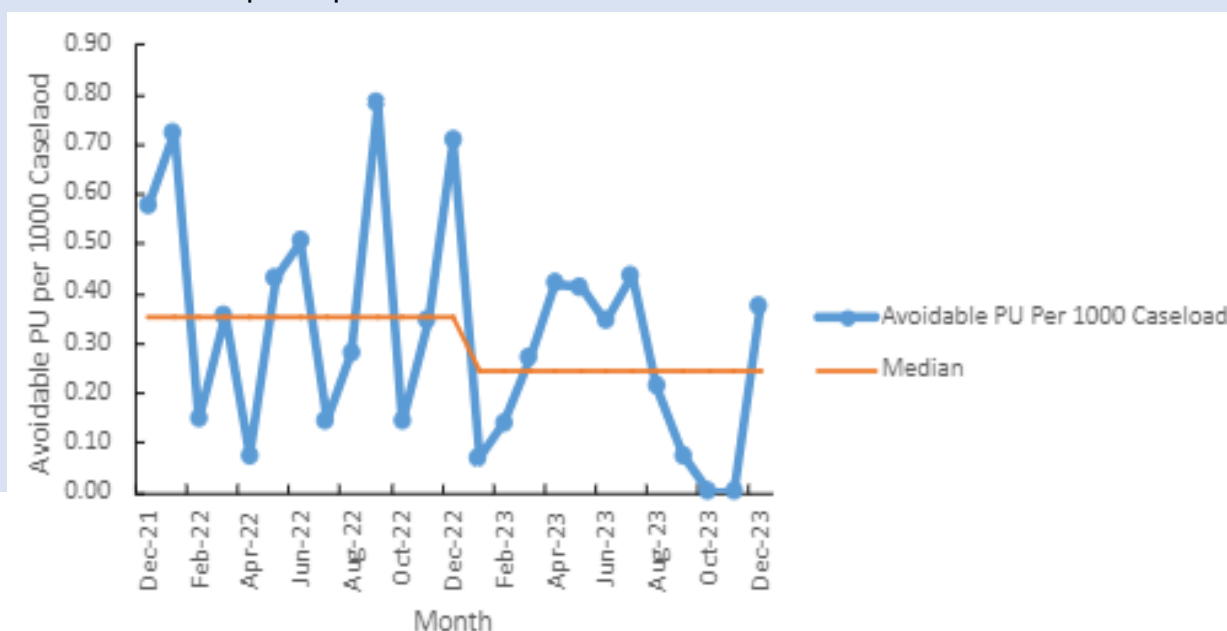
The project aims to identify decline/change in a resident enabling appropriate and effective care, therefore, reducing crisis interventions, encouraging greater resident/carer involvement and preventing hospital admission. A simple framework helps to improve recognition of decline in a resident's condition, prompts some actions to consider and provides simple documentation to record assessment and actions. The framework includes a palliative Performance Scale Tool (PPSv2), Traffic Light System with associated actions, SPAR document to record assessments and actions and ACP- Future Care Plan.

This is being rolled out to Care Homes by PDNs and CHLNs. Education sessions being delivered by PDNs and onward support provided by CHLNs. SPAR-After Death Analysis document also being completed to evaluate whether ACP undertaken, was Preferred Place of Death achieved, was patient seen by GP, DN, ANP in last 4 weeks what support the family received, how they were kept up to date, how well the resident was cared for and how the SPAR tool helped, identifying what signs and symptoms led to the staff recognising the resident's decline.

Reducing Avoidable Caseload Acquired Pressure Ulcers (CAPU) in HSCPs

The primary aim for CAPU was to reduce the median rate of avoidable caseload acquired pressure ulcers by 10% by December 2023. The 3 key areas of focus included:

1. Develop governance round the current reporting systems for caseload acquired pressure ulcers to ensure accuracy of data reporting.
2. Develop leadership within HSCPs around pressure ulcer prevention assurance processes.
3. Revise the red day review tool to ensure a quality focus to identify all learning from caseload acquired pressure ulcers.



The figure above demonstrates that the significant quality improvement activity undertaken across NHSGGC resulted in a reduced rate of avoidable CAPU in 2023 compared to 2022. This reduction from 2022 median rate of 0.35 per 1000 to 0.24 in 2023 equates to a 31% drop. There were two consecutive months where there were zero incidents of avoidable CAPU, October and November 2023.

FOCUS ON FRAILITY GLASGOW ROYAL INFIRMARY

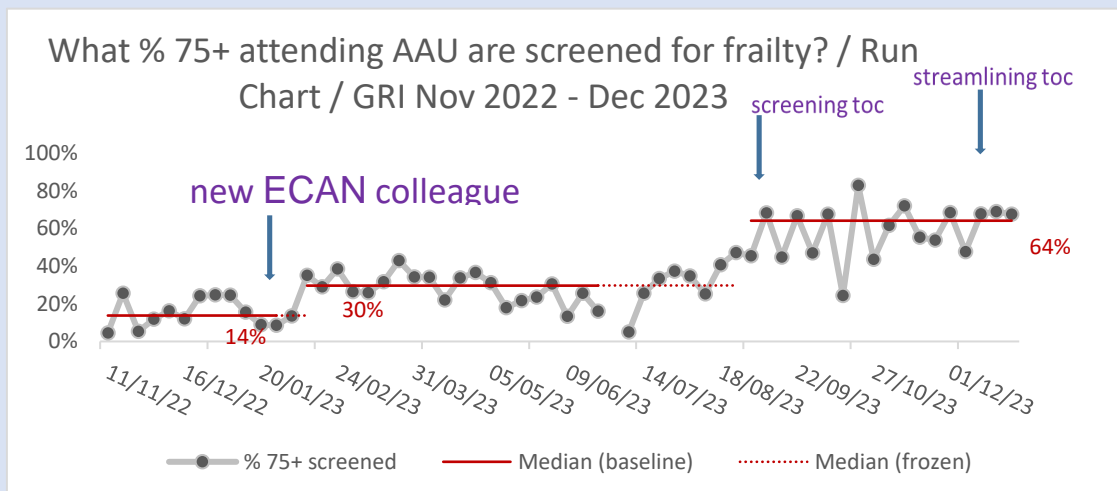
GRI has been part of the HIS Focus on Frailty Programme since May 2023. The focus has been on developing a Front Door Frailty Service and enhancing integrated and coordinated working, particularly between acute and community teams and partners. The team are working towards the development of a dedicated Frailty Assessment Area and the development of alternatives to admission for older people living with frailty.

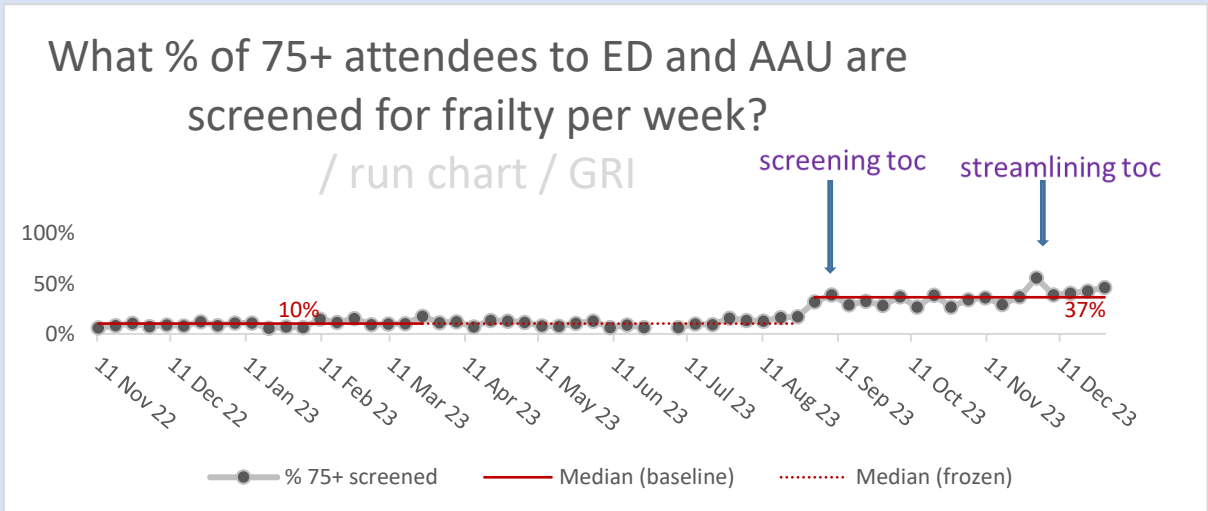
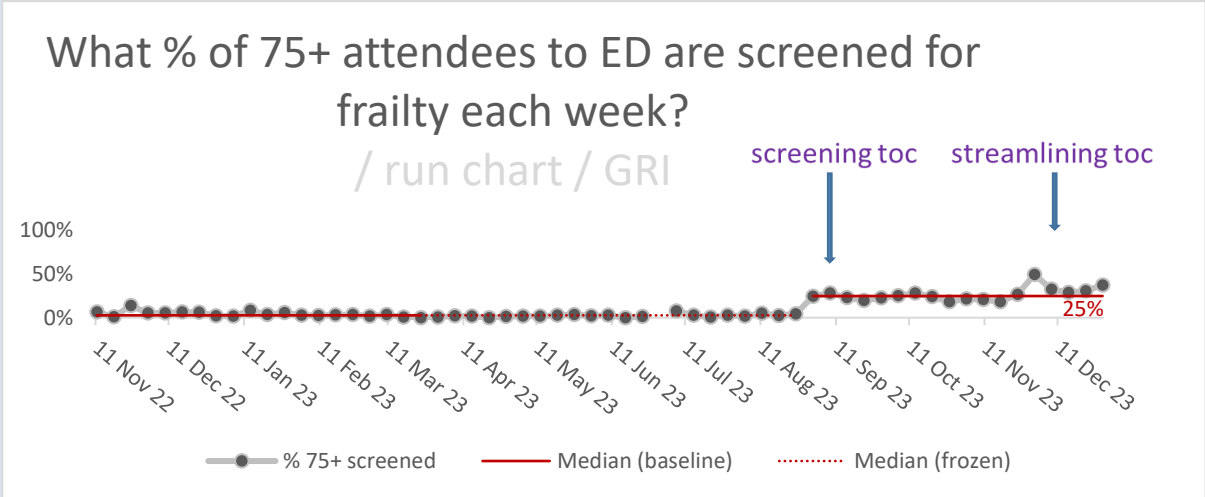


There have been several key areas of focus to date.

1. Frailty identification

Processes have been developed to identify patients with frailty requiring admission to medicine from AAU and ED. The data for ED and AAU show clear improvements.





The above reflects the numbers of attendees screened for frailty regardless of specialty. This is therefore an underestimate of the numbers screened for frailty who are admitted to GRI through medicine, which was the initial area of focus. The data for this group showed that **79% patients admitted through medicine had been screened for frailty.**

2. Streamlining patients with frailty to specialist areas of care to initiate early Comprehensive Geriatric Assessment (CGA).

The benefits of Comprehensive Geriatric Assessment for patients with frailty are well evidenced. Processes have been developed to try and streamline patients with frailty to a dedicated receiving area (ward 53) and downstream Older Peoples Services (OPS) wards.

There has been success in streamlining patients to downstream wards.

December 2023

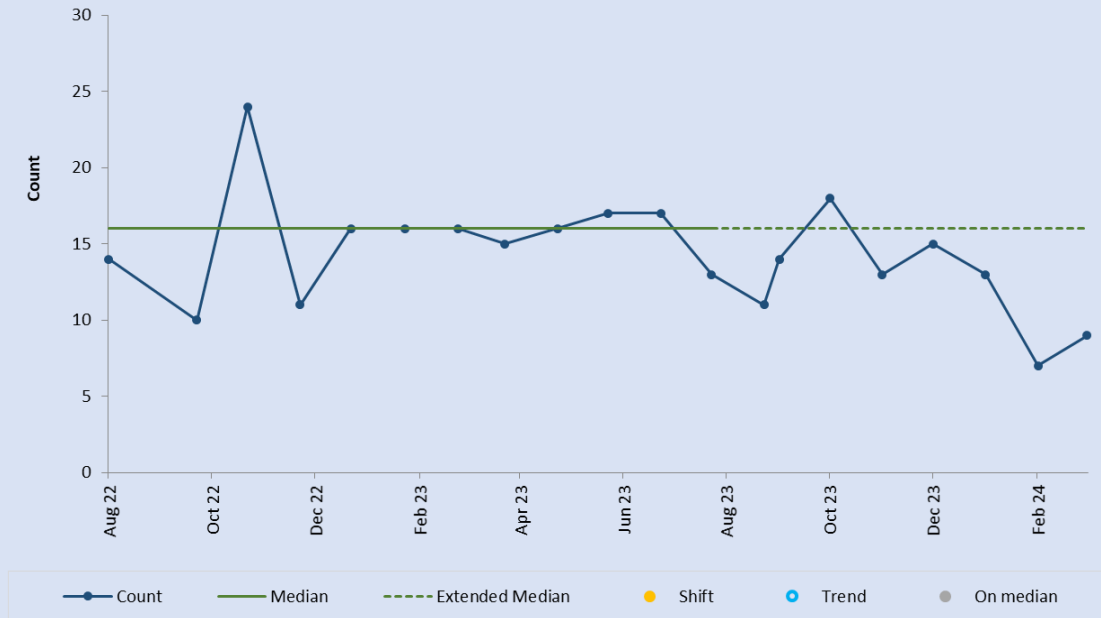
A spot check in December 2023 demonstrated that 96% patients 75 years and over in OPS wards had been screened for frailty, of whom, 96% had frailty.

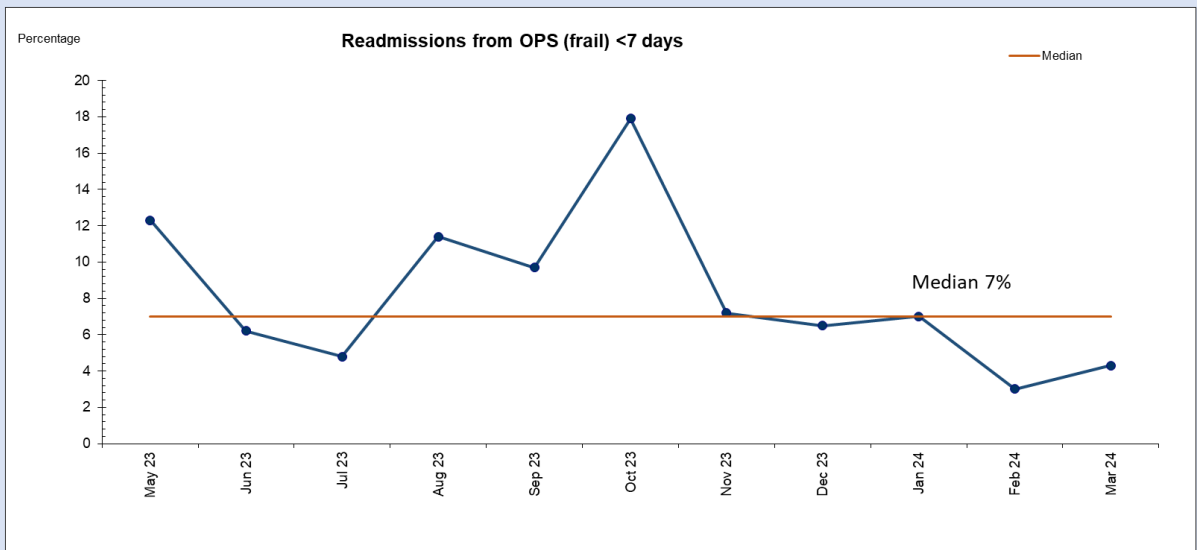
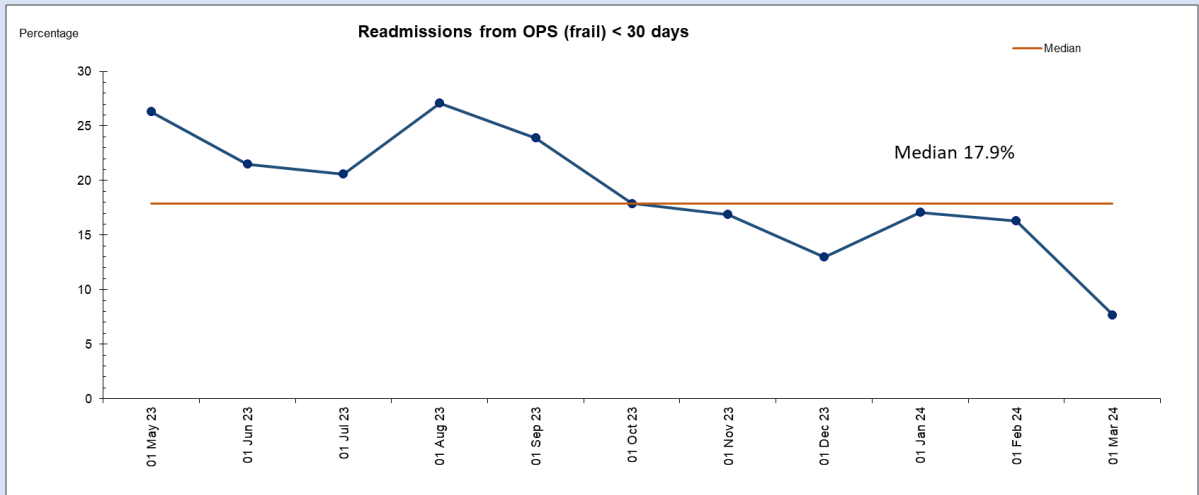
March 2024

A spot check in March 2024 showed that 99.2% patients 75 years and over had been screened, of whom, 91.2% had frailty.

These data demonstrated that screening is facilitating the pull of patients to the right downstream areas of specialist care. Beneficial outcomes, in terms of a reduction length of stay and readmissions, have been demonstrated.

Average Length of stay for Patients identified/ Assessed as Frail





It has been more challenging to streamline patients with frailty to the specialty front door receiving area (ward 53) and work is ongoing to improve this.

3. CGA Huddles

A Frailty Assessment Tool has been developed which gathers key information about patients early and helps identify rapidly the priorities of the patient and their family/ carers.

Daily CGA Huddles have also been developed. These occur after the acute ward round in the OPS receiving area (ward 53). Various MDT colleagues from acute and across the

community/ HSCPs meet in person and/or via MS Teams. The buy in has been excellent and these huddles have facilitated.

- early collateral information gathering.
- key information exchanges and integrated working between acute and community partners, coupled with the building of relationships.
- the enhanced ability to explore alternatives to admission.
- the promotion of earlier discharges in a coordinated fashion.

Discharges from ward 53 have doubled compared to previous months since the inception of these huddles.

Key next steps

- Gain patient and carer opinion on how to further mould and develop the service.
- Develop a fully functioning Frailty Assessment Unit in ward 53.
- Develop services to provide alternatives to admission.
- Continue to enhance integrated and coordinated working.

Waiting Well for Occupational Therapy (OT)

At the beginning of the project in August 2023 people were waiting between 7 and 33 weeks for specialist rehab occupational therapy. This wait can impact on the person's condition, expectations and outcomes and causes increased stress and burden for staff. If no action taken there was potential for the situation to worsen especially during busier times, such as winter months. The gap from where the team were and where they wanted to be in terms of weeks was 15. The initial aim was 'By Dec 2023 all patients within the Northwest Rehab team referred for specialist Occupational Therapy will 'wait well' for a max of 18 weeks and achieve agreed personal outcomes, in line with the recommendations outlined in the Once for Scotland Rehabilitation and recovery: a person-centred approach'.



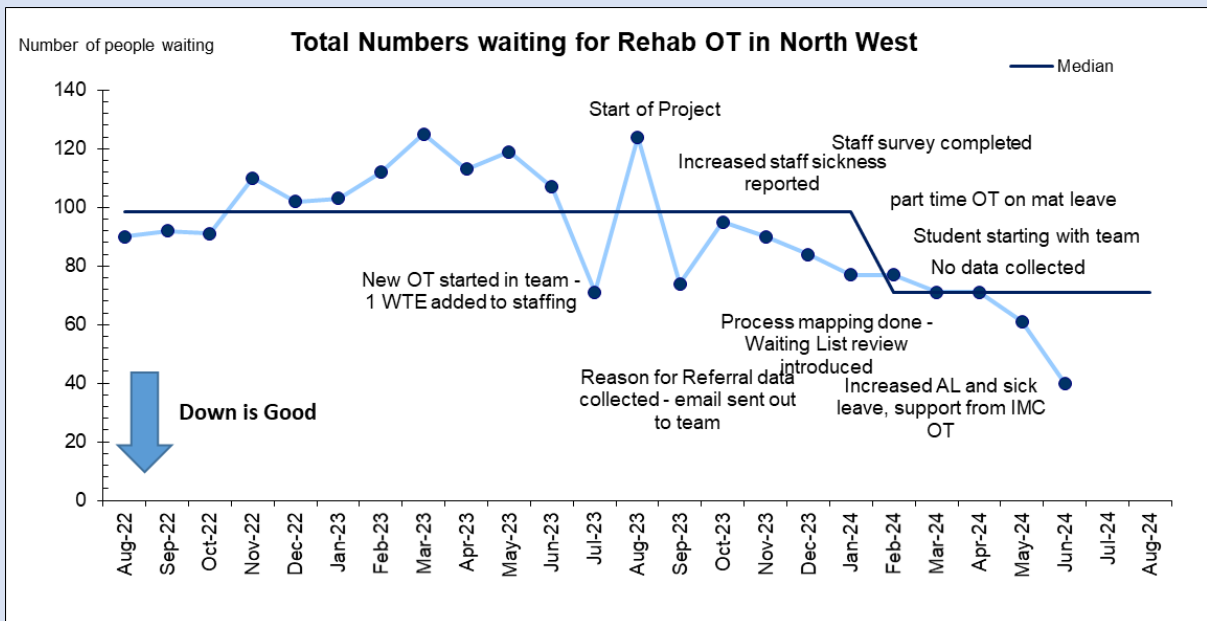
As a result of changes within the team and processes, the number waiting for specialist OT dropped from 124 to 77 people and the longest wait dropped from 33 to 11. Staff satisfaction and confidence were measured via a survey and results were positive.

Phase 2 started Feb 24

Aim: By Dec 2024 90% of people referred for specialist OT will 'wait well' for max 8 weeks before OT Assessment.

It was agreed that the second part of the original aim had not yet been considered within the project and could become a separate improvement project. To fully achieve the new aim, waiting well needs to be defined by service users and measured via feedback from

future service users. Service user surveys were started to gather data on service user perspective on waiting well for Rehab OT services.



Numbers waiting have improved by 68% since starting the improvement project in August 2023, the longest wait is 18 weeks however only 4 people out of 40 are waiting over 8 weeks and 25 are waiting under 6 weeks. The aim is realistic at 90% and has been achieved. The team will aim to maintain this for the next 6 months until Dec 2024.

Next Steps

- Continue Service User Surveys
- Consider feedback, define waiting well from service user perspective.
- OT Team to meet to review changes made and consider any further tests of change.
- Review Dec 2024.



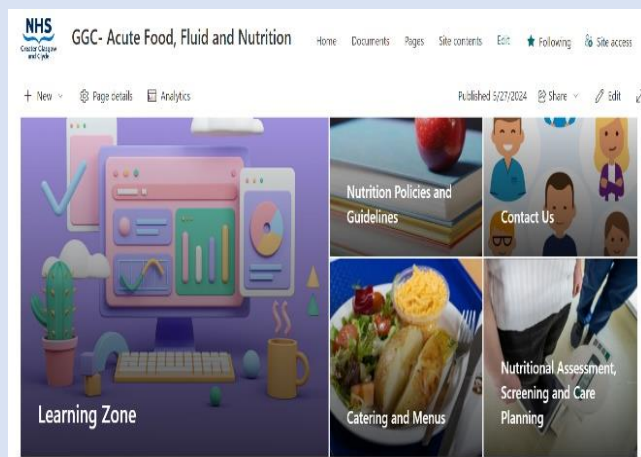
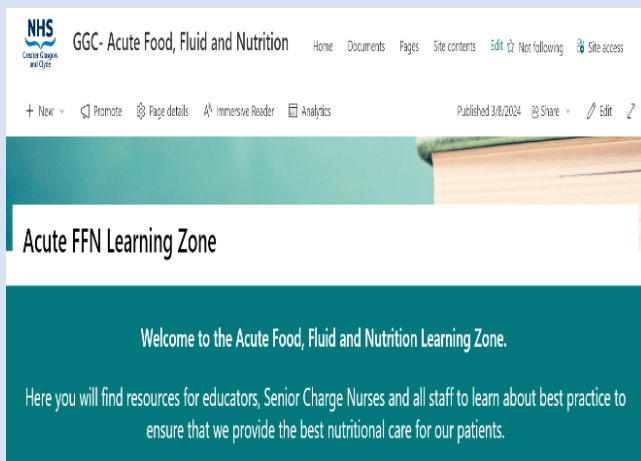
Nursing staff and Allied Health Professionals (AHP) across NHSGGC Acute Services, had difficulty identifying where to access nutritional resources and education related to nutritional care. A variety of educational resources, across several platforms, were in use, without standardised board approved content. Actions identified suggested a combined need to address these issues, update current Nutrition Resource Manual, standardise nutritional education and move content to an easily accessible digital platform.

Aim: To standardise food, fluid, and nutrition (FFN) education resources and information in an easily accessible digital platform for staff working across acute services within NHS GGC.

The project team consisted of 2 Practice Development Dietitians at the Queen Elizabeth University Hospital (QEUH), Glasgow and a Practice Development Nurse from West Glasgow Ambulatory Care Hospital (WGACH), Glasgow.

Methods used by the team included:

- Set up short life working group, consisting of variety of professional roles.
- Subject matter experts reviewed nutritional clinical information and updated guidance.
- Digital platform options considered with SharePoint identified as most appropriate.
- Regular meetings held to review content and layout of site.
- Education resources developed to support diverse staff learning styles.
- Site administrators nominated to continue ongoing review of site, including assuring information governance.
- The completed site published (March 2024) and communicated to all staff via a variety of board wide communications.



The project team have created the Acute FFN SharePoint site, a standardised education resource for use across all sectors, to assure a safe and effective method of education. All acute nutrition related information is in one easily accessible digital platform. Contact

information and referral pathways are accessible through the site. The Acute FFN SharePoint site supports the board key priorities and strategies.

Next Steps

- Undertake overall evaluation.
- Auditing user feedback on accessibility and use of site.
- Site analytics will provide data on usage of traffic to each page and resource.

Placement of Dental Implants Using Dynamic Navigation



Placement of dental implants using Dynamic Navigation; The first clinical application of the innovative technology at NHS GG&C.

Our team, based at Glasgow University Dental Hospital & School, has carried out the first placement of dental implants using the innovative Dynamic Navigation technology (Figure 1).



Figure 1: Registration and calibration of the Dynamic Navigation system before the guided placement of the dental implants.

Placement of dental implants is a routine surgical procedure but requires a high degree of technical skill to avoid complications and ensure that vital structures are not damaged. Dynamic Navigation is an innovative technology allows the surgeon to monitor the cutting edge of the surgical drills in real time on screen in relation to the preplanned ideal implant position. (Figure 2). The real time tracking of the drills and implants provides the operator with the dynamic navigation ability throughout the course of the surgical procedure to improve the accuracy of the placement of dental implants and minimize potential postoperative complications.

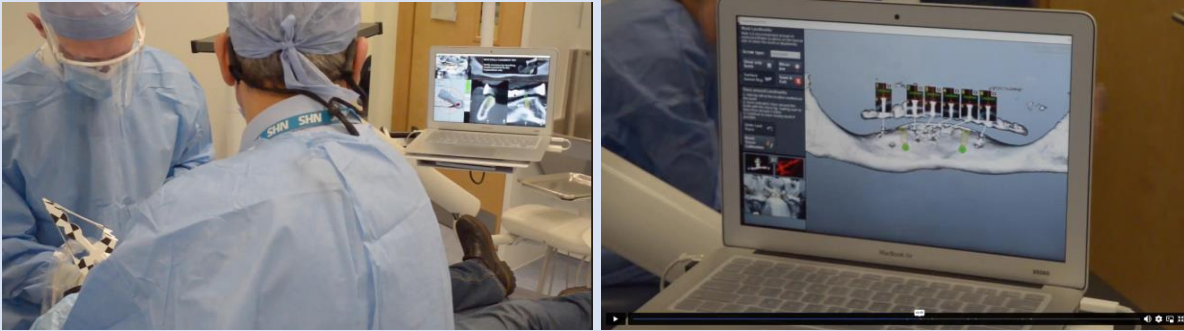


Figure 2. The computer screen displays, in real time, the cutting edge of the surgical instrument in relation to the jaw bones throughout the course of the surgery.

Following the approval of the local Clinical Governance Committee, Dr Douglas Robertson and Prof Ashraf Ayoub have successfully carried out the first dynamic navigation-guided placement of two dental

implants under local anaesthetic at Glasgow Dental Hospital (Figure 3). The placement of the dental implants was clinically uneventful and there were no postoperative complications.



Figure 3. Dynamic navigation-guided placement of the dental implants

Postoperative Cone Beam CT scans showed satisfactory accuracy of the placed dental implants (Figure 4).

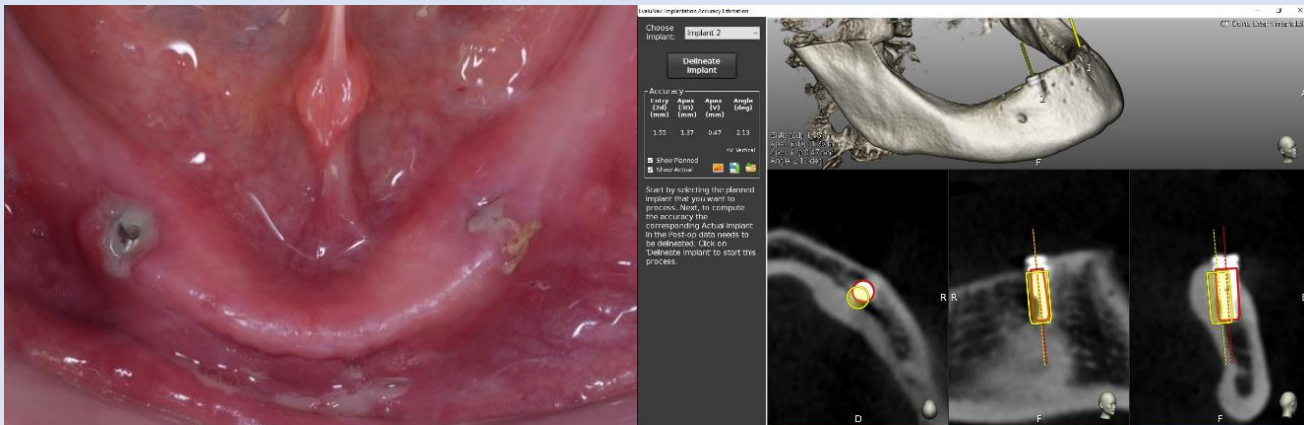


Figure 4.4. Clinical and radiographic images showing the accurate placement of the two mandibular implants.

It is important to highlight that Dr Robertson, Prof Ayoub, and the dental nurses involved in the team, received training in dynamic implant placement. A quality assurance system was set up to evaluate the early cases involving staff evaluation and debriefing, as well as the opportunity for feedback from all staff and patients. Staff feedback has been positive, and the team are keen to continue developing this innovative approach to clinical excellence. Dynamic Navigation has the potential to be utilised in the provision of safe, effective and innovative surgical care in NHS GG&C.

Medicines Administration – A Clinical Guideline for Patient Safety

Alastair Kirk, Practice Development Nurse Acute Services, NHS Greater Glasgow and Clyde

Introduction

Safe and effective medicines administration remain a critical component of health care and patient safety. NHS Greater Glasgow and Clyde recognises the associated risks and recurring themes associated with adverse drug events and created a vision of a clinical guideline which described a consistent application of the fundamentals of safe medicines administration with four risk reduction and safety strategies.

Aim

Medicines safety is a national focus of the Scottish Patient Safety Programme and safe medicines administration is a core component of patient safety in NHSGGC. The overall aim of the Medicines Administration Guideline is to provide a platform of consistent



practice in the safe administration of medicines by all routes to all patients. The objectives are to embed the fundamental and specific safety processes and risk reduction strategies for all practitioners administering medicines across all clinical environments, reducing adverse drug events, and therefore enhancing patient safety.

Method

An established committee, with a primary objective to improve medicines administration safety, identified the need, while reviewing the Safe and Secure Handling of Medicines policy, to develop a new guideline to support best practice in medicines administration. The vision for the guideline was to consolidate the fundamentals of safe medicines administration with a suite of four risk reduction strategies and supplementary resources for healthcare practitioners to refer to and learn from while administering medicines

The fundamentals of medicines administration:

- Minimising non-urgent interruptions
- Chance to check.
- Independent two-person check
- Reducing omitted/delayed medicines

Results

A series of webinars over launch week introduced the clinical guideline to staff from all sectors and specialties and an introductory supply of the visual prompts were delivered to all clinical environments across ten hospitals in Acute Services.

To enhance the impact of the guideline, a new eLearning module on LearnPro has been developed and promoted amongst all practitioners involved in medicines administration. Since launch, over 900 staff have completed the module. This module has been adopted as one of the mandatory role specific learning requirements for all Registered Nurses and Midwives.

A video demonstrating the correct independent two person check process has since been produced. This involves each practitioner carrying out each individual step of the process independently, from preparation through to administration. Rather than regarding it as a repetitive, routine task, critically thinking of reducing potential error and harm. The process is enhanced by both practitioners applying Chance to Check and maintaining the principle of removing non-urgent interruptions during the independent two-person administration process.

The guideline provides a focus on reducing omitted medicines and improving compliance with timely administration of time critical medicines. Improvement projects are underway in relation to Parkinson's Disease medication, and additional plans are progressing for similar improvements associated with Diabetes and Myasthenia Gravis medicines.

Conclusion and Next Steps

The foundations for a structured quality improvement and assurance programme have now been laid. The next steps are to maintain progress through ongoing work to review and learn from near misses, incidents, and observations to better understand medicines administration challenges and seek ways to continually improve. Immediate plans are already underway to:

- Strengthen medicines safety assurance processes.
- Develop additional targeted learning resources.
- Reinforce the safety strategies through a series of blogs.

Digital Malnutrition Universal Screening Tool (MUST) Completion Within 24 Hours of Admission to Adult Neurosurgical Ward



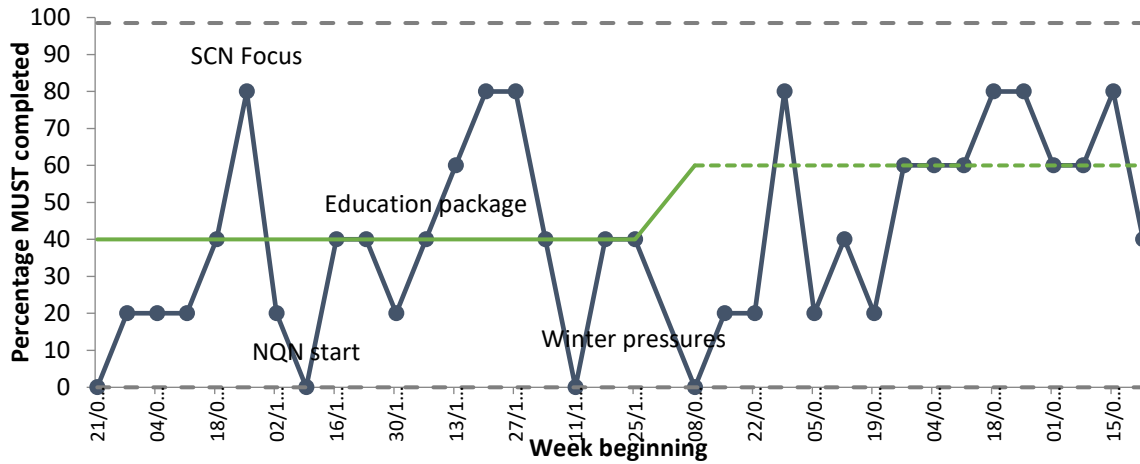
Malnutrition is a state of nutrition in which a deficiency of energy, protein and nutrients cause measurable adverse effects. Nursing staff have a responsibility to ensure that nutritional screening using a validated screening tool (e.g. MUST) is carried out within 24hrs of admission to identify any patients who are or may be at risk of malnutrition. (Right Patient, Right Meal, Right Time policy, NHSGGC 2023). Within Ward 65, Queen

Elizabeth University Hospital (QEUE) the current completion rate was 20% of MUSTs within 24 hours of admission.

Aim: By May 2024, 50% of patients in Ward 65, QEUE will have a digital MUST score calculated within 24 hours of admission.

The project team included Senior Charge Nurse, staff nurses and clinical educator from ward 65. A process map was developed to understand the process on digital documentation completion during a patient admission. The team then developed a Driver Diagram and identified the primary and secondary drivers. They identified interventions required to make improvement changes. As the digital version of MUST was a new format, the focus was on developing an education package to support all staff with digital clinical notes.

% of Digital MUSTs completed within 24 hours of admission in Ward 65, QEUH



The project demonstrated an initial average of 40% completion rate over a 16-week period, this increased to 60% in the period following the critical winter period.

Although there is an increase in completion of digital MUSTs within 24 hours to 60% this is not a sustained shift and further improvement focus is required. External factors have an impact including winter pressures and leadership focus.



Next Steps

- Continued development of education package
- Roll out of Digital Clinical Notes across NHSGGC Acute Services



The digital calculation of BMI really helps staff to complete MUST in a timely manner – SCN Ward 65

Empowering Patients to Self-Administer Vitamin B12 Using a Values-Based Approach



Introduction

The Community Treatment and Care (CTAC) Service in East Dunbartonshire deliver a wide range of nursing interventions for patients in a clinic setting. This includes administration of Vitamin B12 intramuscular injections for the treatment of the long-term condition pernicious anaemia which requires ongoing management. Currently, of 3125 patients on the CTAC caseload, 41% require appointments for administration of Vitamin B12 injections.

CTAC nursing staff highlighted that some patients struggled to attend appointments, citing reasons including childcare, transport issues and work commitments. Through discussion, staff recognised some patients would like to self-manage their condition by administering their injections as this would eliminate the pressure to attend fixed appointments. As a result of this patient feedback the team identified an opportunity to develop and test a teaching package to enable self-administration of Vitamin B12 injections.

Aim

To develop a robust, safe, effective, person-centred teaching package to enable patients to self-manage their long-term condition of pernicious anaemia.

Methodology

Scoping

Nursing staff informed patients of the test of change and through values-based discussions identified those who were keen to be involved. Patients were asked what mattered to them and how they felt they could benefit from taking part. A scoping exercise was then commenced to establish practices already in place nationally and a review of relevant literature undertaken.

Governance

An SBAR outlining the project with risk assessment was completed prior to the pilot commencing. A short life working group was set up to collaborate with multidisciplinary team stakeholders to ensure all governance was considered.

Staff Involvement

The CTAC staff were instrumental in the success of this project. Staff engaged throughout all stages of the process and clinical supervision was used as a structured support tool. Suitable patients attended an extended appointment during which teaching, and observation was carried out to ensure competence and safety.

Patients were made aware they could contact at any time for further support or if their ability to self-manage changed.

Quality Improvement

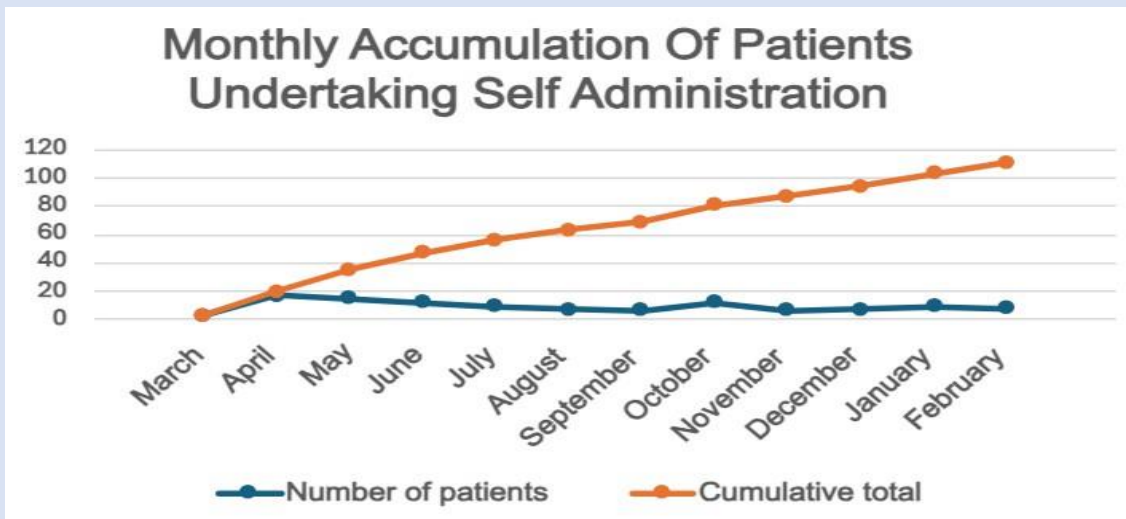
Staff created a teaching package and resources using PDSA cycles which were refined following staff and patient feedback as the programme developed.

A pilot patient was identified and began self-administering in March 2023. Patients were recruited gradually initially focussing in one cluster area of East Dunbartonshire then extending across the HSCP.

Results

On review of the project in March 2024, 111 patients have been supported to self-manage. To date, only 2 patients have self-referred to the CTAC service resulting in a 98.2% success rate. Patient feedback has been overwhelmingly positive and demonstrates their journey to empowerment. Patients found the teaching materials and methods accessible, helping with their confidence to self-manage. As well as the individual benefits, some patients highlighted that implementation of this project has “relieved strain on the nurses and NHS”.

To date, with 109 patients self-managing this has enabled CTAC to reabsorb approximately **18 hours** of trained nursing appointments over a 3-month period which has released more capacity within the CTAC service.



Conclusion

Using a values-based approach allows patients to remain at the centre of the decision-making process. Many patients try to self-care in aspects of their health and with robust governance, appropriate teaching and resources can be supported to do so resulting in better patient outcomes.

Next Steps

- Widening the implementation of this change in practice, sharing learning across HSCPs to assist improvement in patient outcomes board wide.
- Staff continue to discuss self-administration with their patients and offer teaching appointments if appropriate.
- The third cluster will now be included in the self-administration project, and it is expected that data collected will demonstrate an increase in number of patients self-managing.
- Consideration for further opportunities to teach self-administration of other medications will be explored.

“This is a great program that promotes independence and self reliance. I don’t need to arrange appointments for a nurse to administer the injection which allows them to deal with other work”

“This saves me going out and I don’t need to rely on public transport”

“great as I struggle to leave the house on my own now”

“Due to my work it has made things much easier for me to ensure the injections are done without delay”

“I work in NHS and I also have 2 children it’s given me the ability to self administer at a time that suits me around work and children’s commitments without worrying about missing or having to reschedule appointments”



“It has given me a confidence that I didn’t have before in that I can be in control of what I do to my body and a sense of responsibility that it’s down to me to order, prepare and inject the B12 that helps me”

“I no longer need to rely on my son taking time off of work to bring me to my appointments”

How Early Active Mobilisation of Patients within the RAH ICU was Increased by Physiotherapy Led to Changes to Practice.

Lauren Ball & RAH Surgical Physiotherapy Team RAH

Early active mobilisation has been widely acknowledged to be hugely beneficial to patient's recovery in Critical Care.



Increases:

- Functional level at date of hospital discharge
- Improves Quality of Life indicators (1).

Reduces:

- The prevalence of ICU acquired weakness.
- Risk of critical care neuropathy (including foot drop),
- Length of stay and Ventilator Days
- Risk of secondary MSK complications e.g. soft tissue contractures, loss of bone density, loss of functional ROM (2).



Our aim was:

By May 2024 we wanted to increase the % of patient mobilised, fitting our criteria, within ICU to 85% in line with the GPICs Guidelines (3).

Methods

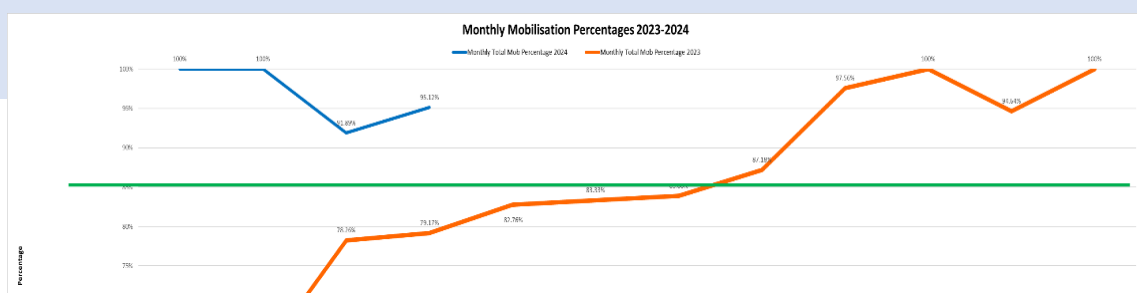
In January 2023 we used QI tools to assess the barriers to mobilising patients and our current process to identify patient who were fit to mobilise. We identified that our process was lengthy, and we were being delayed by lack of communication with the MDT regarding appropriate patients.

We agreed guidelines for appropriate patients to mobilise with the ICU consultants which stipulated: Patients must be responsive to verbal stimulation and obeying commands, PEEP <12, FiO2 <80%, CVS stable and their Inotropes/Vasopressors had not been increased within 2 hrs amongst others. We used these to determine our starting point and the % of patients who met the criteria who were successfully mobilised in January 2023. The table below shows our findings.

Month	% of Patients Monthly who were classed as Not Treated	% of Patients Monthly who were classed as Mobilised
January	45.58%	54.41%

We saw huge potential for improvement in these numbers and in March 2023 we began attending the morning handover in ICU with medical staff and opening a conversation regarding active mobilisation.

We have continued to collect data from January until April 2024 to show our progress towards meeting our aim. This can be seen on our graph below. The green Line represents our aim of 85%. Making it clear we are exceeding our aim.



What we learnt

- More potential for improvement
- Over Feb-April 2024 it's clear to see fluctuations in our data, during this time we had– Rotation Changes, New Nursing staff, Unexpected Leave, 2 Students and On Call Training of Staff commitment.
- Highlighted the need to future proof and plan for the unexpected.
- MDT approach imperative – medical staff and ACCP's encouraging and advocating for mobilising patients by creating prompts in the handover checklist.

Next steps

- Continuing “Hug Therapy” – Increase family involvement in rehab – ongoing encouragement of independence out with Physio Sessions
- Consolidate OT input with patients – Now attending ICU morning handovers.
- Changing Carevue documents – more detailed prompts Medical/ Nursing and Physio
- Establish nursing staff training into their formal induction to ICU.
- Training of established nurse



Introduction:

ANP's working within the home visiting service identified barriers to timely access to medication for some of the most frail, housebound patients with an acute clinical presentation. They noted a significant delay from the time of assessment to commencement of treatment when patients relied on carers/relatives or pharmacy delivery services. This increased risk of further deterioration, potential hospital admission and poorer outcomes due to the delay in starting treatment (SIGN:167)

Aim:

Enable home visiting ANP's access to emergency medication and initiate first dose medication to prevent deterioration of an acute presentation.

Methodology:

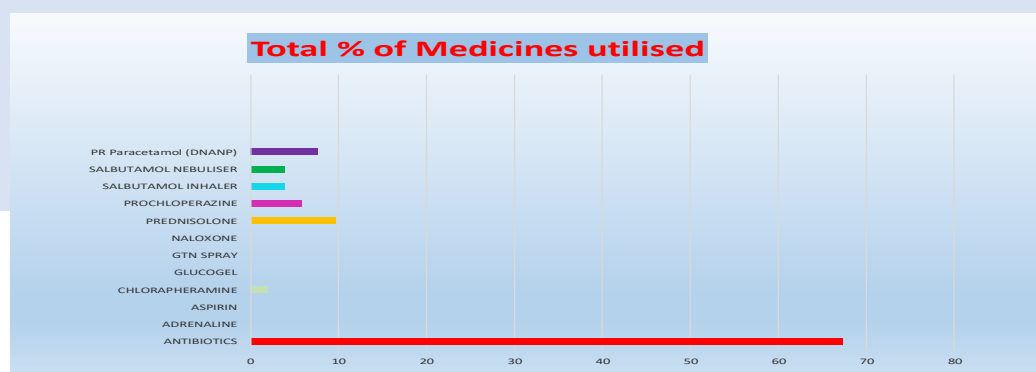


The ANP service used a quality improvement approach, utilising the 4 pillars of advanced practice to:

- Scope current ANP practice across wider HSCP and National Teams and review current research.
- Engage with all relevant stakeholders to explore scope for medication initiation and storage in line with Policies, Guidelines, and medical-legal requirements.
- Establish a required list of medication based on urgent care.
- Develop a Standard Operating Procedure outlining clear principles and processes for initiation of first dose medication and governance measures for storage and stock control and record keeping.
- Supply secure lockable safe storage facility.

Results:

During the 12-month period, a total of 48 medications were initiated by the ANP at the time of diagnosis. Most of these medications were antibiotics for LRTI, UTI's and Cellulitis and steroids for COPD exacerbation. Which enabled prompt commencement of treatment and prevented further deterioration. There were no incidences of emergency medicine initiation.



Conclusion and next steps:

Evaluation from the test of change demonstrates patient benefit from swift access to treatment. In particular, initiation of the first dose of antibiotics. Following review of medicine used and feedback from wider ANP colleagues, stock levels were amended, and PR paracetamol was added to the list.

This test of change has now been fully implemented across wider HSCP ANP services and adopted across GG&C with the author, ANP Douglas Bell, receiving National recognition as the winner for Innovation at the National Health Awards in November 2023 & judge's choice at the Advancing Practice, Advancing Care Scotland National Conference 2023.

NHSGGC Public Protection Strategy 2023-2024

Safe Guarding It Matters To Us - NHS GGC Public Protection Strategy 2023 - 2026 was formally launched on 20 February 2024, coinciding with National Adult Support and Protection Awareness Day. The strategy provides a clear vision statement, public protection principles and six key strategic aims which will help us to achieve our vision. A delivery plan is in place to ensure focus and support of senior leaders and their teams across the objectives. A range of policies and guidance documents have been developed and updated to ensure NHSGGC fulfils its duties for keeping the unborn child, children, young people and adults safe from harm and abuse. For example, an NHS GGC Public Protection Policy which sets out the key responsibilities for all health staff; an NHS Neglect Policy which provides all health professionals within NHSGGC with a framework and consistent approach to identifying, assessing and supporting babies, children, young people and vulnerable adults, where neglect may be a concern; and the development of NHS GGC Adult Support and Protection (ASP) Guidance which includes a clear referral process for submitting an AP1 form to support staff execute their ASP responsibilities. We have reviewed and established robust NHS GGC public protection governance arrangements ensuring appropriate representation of our leaders and managers at all levels of the public protection governance structure.

6. Capability Building

6.1 Clinical Risk Training

6.1.1 Significant Adverse Events Reviewer Training

299 people undertook training for reviewers of Significant Adverse Events between March 2023 and April 2024, which adds to the 565 who have been trained since 2021. The format of training for SAE reviewers is currently being reviewed to increase flexibility of access through a hybrid model of e-learning and live sessions.

6.1.2 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. 72 staff within NHSGGC have completed the NES Duty of Candour Course between April 2022 and March 2023.

6.1.3 Commissioner Training

A LearnPro Module has been developed to assist SAER Commissioners with their role within the SAER process. Module 305 Commissioning of a Significant Adverse Event can be found on LearnPro under Specialist Subjects. This can be accessed by anyone wishing to know more about the commissioning process or Clinical Risk can arrange guided sessions. As of 31st March 2024, 141 people have accessed the training across NHSGGC.

6.2 Quality Improvement Capability

The NHSGGC Quality Improvement Capability Plan 2021-23 was approved at the Healthcare Quality Strategy Oversight Group in October 2021 and ended in December 2023. This plan provided 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 were:

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.

6.2.1 Engagement and coordination

A toolkit to support services to identify gaps and build QI capability was developed, tested and is available to all Acute Sectors and Directorates and HSCPs.

6.2.2 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	37
Scottish Improvement Leaders (ScIL) / Improvement Advisors (IA)	62
Scottish Coaching & Leadership for Improvement Programme (SCLIP)	118

Table 6.2.2: 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 2024. From NHSGGC, there were 7 applications submitted from Medical, Nursing & Midwifery, Pharmacy and Healthcare Scientist staff.

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 ended 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 39 of SCLIP concluded in February 2024 with 16 successful applicants from NHSGGC that will participate in a programme running from November 2024.

6.2.3 NHSGGC Quality Improvement Training

Quality Improvement Fundamentals

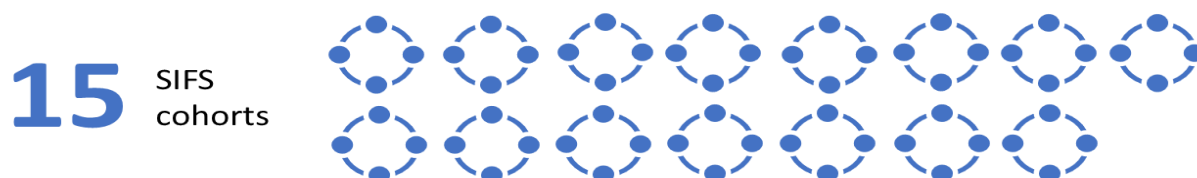
A Learnpro Module was developed in 2021 to support NHSGGC staff to understand Quality Improvement. The module aims to provide awareness and basic understanding of the importance, methods, and successes of Quality Improvement within NHSGGC.

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 2023 and March 2024, 603 staff completed the module which totals 2,624 staff completing the module since it launched in February 2021.

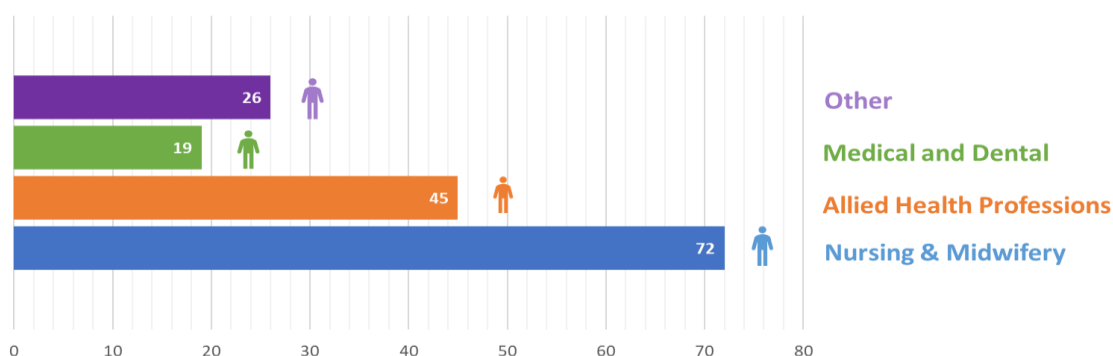
Scottish Improvement Foundation Skills (SIFS) Programme

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 2023 to March 2024, 15 cohorts totalling 162 staff across NHSGGC completed the programme.



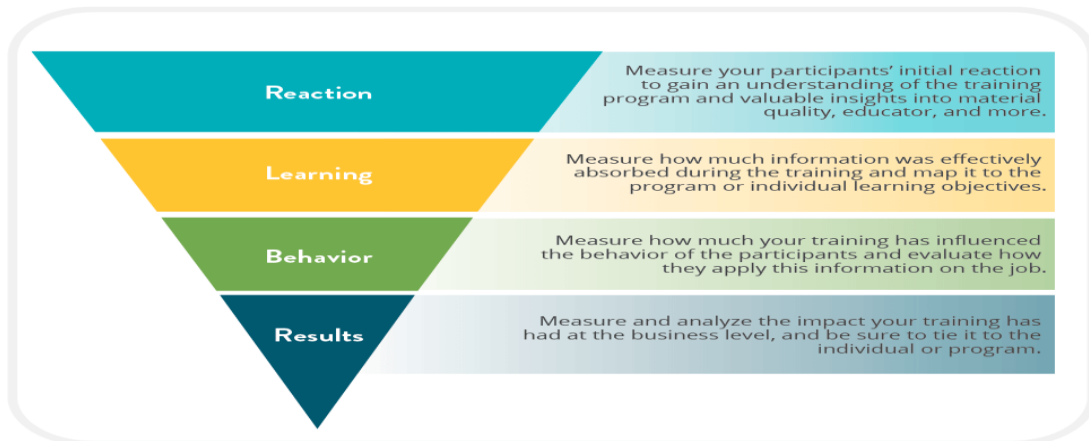
162 Staff across NHSGGC



6.2.4 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:

THE KIRKPATRICK MODEL



Reaction

95% of delegates who completed the programme stated they would be likely to apply their learning to their role.

94% 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 1 (Not aware) 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:

- I believe I have a better understanding of how to look for areas of improvement and rather than just think we could do that better; I can now critically look at the issue and think how can I apply the theory learned.
- Actively looking for next QI project in my new rotational area
- The way I approach QI work has completely changed! I'm spending more time and asking more questions of my colleagues regarding the planning, aims, measurements. Also using the tools to capture discussions and ideas.
- I take on new challenges, help colleagues on improvement projects and help management identify where changes may be required in the future.
- I feel more confident in myself and my project, I feel I'm have the ability and skill to change my practice and other's practice.
- Recognise the significance of small changes and be aware to monitor outcomes before and after implementing any change.

Results

The process to measure the impact of the training on the organisation requires short semi-structured interviews to take place. This process was tested out with five delegates who had completed SIFS cohorts in 2023 and 2024.

Of the five delegates who agreed to be interviewed.

- 4/5 had completed their projects.
- 4/5 had completed projects resulted in demonstrable improvements.
- 4/5 had presented the results of their projects to committees or events.
- One delegate commended for her work.

Some examples of positive impacts of the projects completed:

- Patients discharged home earlier due to being mobilised on the same day as their surgery (day 0)
- Incidents, related to reset issues with vaccination fridges, have been reduced by creating a training video accessible via mobile phone.
- Introduction of laminate surveys by health visitors which are more accessible to those for whom English is a second language and those who cannot read at all in English or in their first language. Savings on paper and postage.
- Serial prescribing project which has saved GP time writing prescriptions, saves admin time answering phone calls about prescriptions and provides a better patient experience.

NHSGGC Quality Improvement (QI) Network

In 2017 the first QI Network was developed but due to the emergence of the Covid 19 Pandemic this network was paused. The absence of visible and tangible board-wide QI support for those on the front lines between 2020 and 2023, had been keenly felt by clinicians, with QI leaders identifying a need to develop a QI faculty, network, and resource hub to enable staff to learn, connect, share and build confidence to practice QI at all levels.

In February 2024 the NHSGGC QI Network Hub SharePoint Site became available hosting information on QI learning, local and national training information, resources and a “Request Support” function. March 2024 saw the launch of the first NHSGGC wide, QI network event designed to provide a mechanism for QI learning, training, sharing, and networking across the system.



Figure 6.2.4a: Depicts the landing page for the NHSGGC QI Network Hub SharePoint Site.

This iteratively tested model of QI support and networking is open to all staff, regardless of profession or role, spanning across traditional boundaries. Supported collaboratively between the CGSU and leaders of QI within the Board, the network aims to improve safety and person experience for all users and providers of NHSGGC services by modelling, encouraging and signposting QI approaches, methodology and support in alignment with the NHSGGC Quality Strategy. There are three components of the NHSGGC QI Network acting as resources for staff.

NHSGGC QI Network component	Function	Responsibility
NHSGGC QI Network Hub (SharePoint)	Hosting information to aid learning and sharing, signposting of resources and support to access local/national training information and 1:1 QI advice/support	Monitored and maintained by the CGSU
NHSGGC QI Network, MS Teams page	Facilitating networking and sharing opportunities.	Monitored and maintained by the CGSU. Populated by the Network Hub and Members
NHSGGC QI Network Learning and Sharing Events	Facilitating 3-4 virtual sharing, learning, and networking events per year	Coordinated and supported by CGSU with content and presentations developed and delivered by the Network Hub and members

Table 6.2.4: Components of the NHSGGC QI Network

There are many profession/diagnosis-specific satellite and QI and Improvement focused groups within NHSGGC with a wealth of QI knowledge, experience, and a desire to collaborate. We plan to support those groups to connect and collaborate through the network weaving mechanisms of the NHSGGC QI Network.

7. Plan for 2024-2025

NHSGGC Board objectives:

COBC6	To provide safe and appropriate working practices that minimise the risk of infection, injury or harm to our patients and our people.
COBC9	To continuously improve the quality of care, engaging with our patients and our people to ensure healthcare services meet their needs.

Some of the key priorities and objectives for the year ahead include:

Partnership working

- Complete the business case for the new NHSGGC Incident Management system.
- Work with key stakeholders to enhance the use of data dashboards within NHSGGC.

Review and publish relevant policies

- NHSGGC Interventional Procedures Policy
- NHSGGC Consent Policy on Healthcare Assessment, Care & Treatment
- NHSGGC Duty of Candour Policy

Reviewing our approach

- To continue with our improvement aim and activity to reduce the number of breached guidelines
- To learn from other Boards in NHS Scotland in relation to their policies and processes for managing SAEs, and develop recommendations for NHSGGC going forward.
- To develop a model of Clinical Governance Reviews to monitor if our clinical governance groups and committees are working effectively, and any areas for improvement

Building capability and capacity

- Implement a new Quality Improvement Capability Plan for 2024 to 2026, as part of the implementation of the new NHSGGC Healthcare Quality Strategy

Quality improvement programmes

- Progress Quality Improvement Programmes for Deteriorating Patient, Falls, Perinatal, Paediatrics, Mental Health, and Primary Care, by identifying teams to start testing and measuring change ideas, which will reduce harm and improve the experience of patients.

8. Conclusion

Our 2023-2024 report highlights some of our achievements and key activities throughout the year.

2024-2025 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.

We will also build on this report going forward to enhance examples of progress and clinical governance activity within the Acute Services Division and Health & Social Care Partnerships.