Borders NHS Board

CLINICAL GOVERNANCE & QUALITY REPORT – NOVEMBER 2017

Aim

The Board is aware of clinical issues that have been reported previously through the Clinical Governance Committee, related to the rising Hospital Standard Mortality Rate (HSMR) and improvements required following recent inspections.

The intention to focus on key clinical interventions to improve quality and safety has been described (Clinical Governance Committee, July 2017) and the Nursing Directorate has formally launched the NHS Borders 'Back to Basics' programme, the delivery mechanism to support implementation of Excellence in Care.

This special Clinical Governance and Quality report is designed to inform the Board of progress in these areas and to describe the reporting requirements on clinical quality improvement going forward.

Background

A review of compliance with education standards has highlighted potential deficiencies regarding clinical education, documentation and skills within nursing & midwifery which could impact detrimentally on patient safety and good clinical governance.

In October 2015 an internal audit report on "Mandatory Staff Training" made recommendations with an overall rating of high risk, highlighting training identified for staff not being completed; training sometimes exceeding time allocated; a lack of information on follow up to ensure that staff who miss or cancel training are re booked.

The Clinical Governance Committee has also received reports outlining the approach to quality improvement that described the need for improvement (latterly July 2017).

Reviewing compliments and other positive feedback as well as complaints, adverse events and mortality reviews identified that these two sides of the same coin can be used to create an improvement plan and provide the platform to become a learning organisation. Recent inspection findings also added focus to this thinking along with support from the Healthcare Improvement Scotland mortality review team responsible for monitoring HSMR performance across the country.

It has been accepted that our broad aim is to:

To develop a learning organisation where learning from all experiences directs our approach to quality improvement: delivering safe, effective and person centred care throughout the patient's journey.

Outcomes to enable this would be:

• 80% inpatient wards/areas within the BGH will have identified and commenced a programme of quality improvement that will be guided by ongoing learning from experiences by December 2017.

• 80% of directorates/services/clinical areas across the organisation will actively use learning gained from all experiences to guide their quality improvement approach to delivery of safe, effective and person centred care for all patients by December 2018.
While there are many areas for improvement on which the Board could focus, the first year's priorities are highlighted with these system level measures:

1. Communication with patients and families – aim to effectively engage with 100% patients and families by June 2018. Reducing complaints with an aim for each clinical area to incrementally improve to achieve more than 300 days between upheld complaints by March 2019.

2. Falls prevention and falls reduction – aim to reduce falls by 25% December 2018, with a view to eliminating falls with harm.

3. Tissue Viability – Zero tolerance of developed pressure ulcers from April 2018.

4. Food, Fluid and Nutrition standards – Work with Healthcare Improvement Scotland's Tailored Response Team (TRIST) who will provide bespoke improvement advice and coaching for this specific issue, which they recognise is not well developed across Scotland.

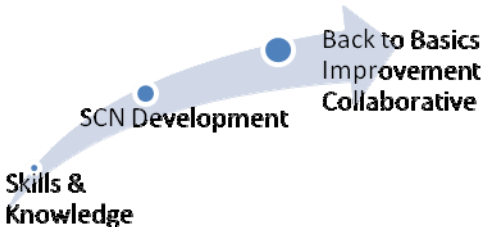
5. Deteriorating patients – sustained improvement of 95% patients suffering clinical deterioration recognised promptly and escalated appropriately by December 2018.

Summary

Excellence in care – 'Back to Basics programme' (B2B)
The NHS Borders programme of improvement launched by the Nursing Directorate aims to deliver the improvement plan agreed with Healthcare Improvement Scotland following the Food, Fluid and Nutritional Care unannounced inspection. Back to Basics is an improvement programme which will take a back to basics approach to nursing care. It will allow the nursing team (and others but with nursing to lead) to refocus clinical teams on delivering excellence in care for every patient, every time.

This programme will be delivered in partnership and will involve nurses, clinical support workers, consultants, junior doctors and the range of allied health professionals. It will be led by the Nurse Director and supported by the associate nurse and medical directors, heads of service, heads of quality & clinical governance and training & development. It will also be supported by our colleagues in Healthcare Improvement Scotland, NHS Education Scotland and the Chief Nursing Officer's office in the Scottish Government.

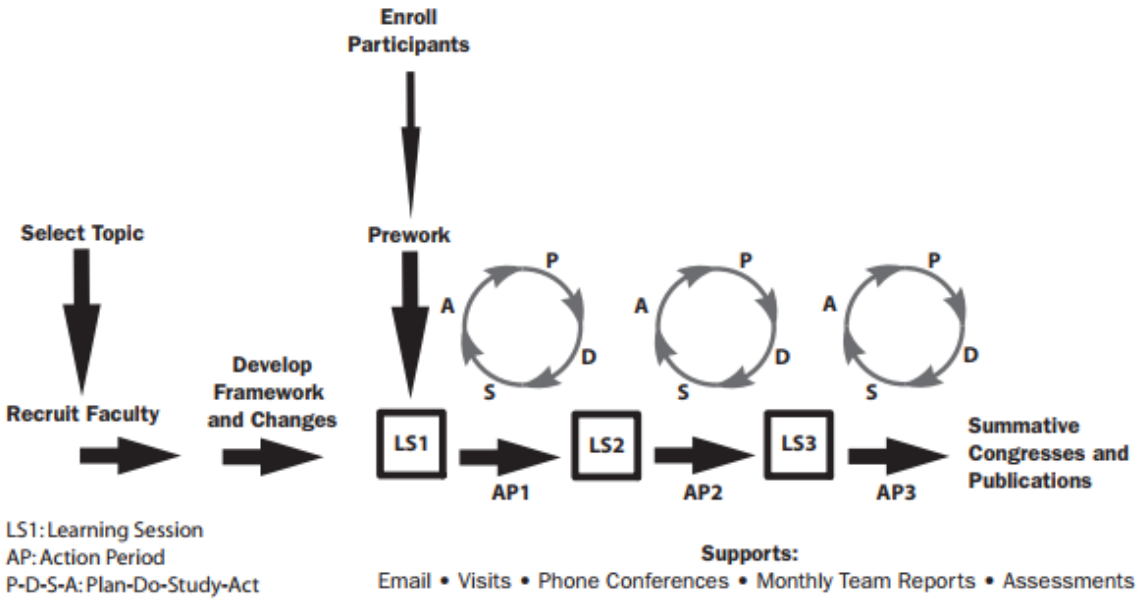
There are three main programmes that will be the core of 'Back to Basics'. These are:



Improvement method - Improvement Collaborative
The approach being adopted to deliver this programme of work is a mini 'Improvement Collaborative'.

The Collaborative approach was developed by the Institute for Healthcare Improvement (IHI) and they describe the approach as one that can deliver the most intensive front-line improvement work. Traditionally these programmes are designed for organisations committed to achieving sustainable change within a specific topic area. Through shared learning, teams work with each other and the 'improvement faculty' to rapidly test and implement changes that lead to lasting improvement.

The traditional approach will be adapted to ensure that it is fit for purpose for the size and scale required within NHS Borders. Learning periods will be designed to achieve maximum benefit for minimum disruption to the service. Between learning sessions there will be action periods designed to support iterative testing of changes at the point of service delivery. The classic model below will be adapted to meet our needs. In particular our staff at all levels and across all disciplines will be more engaged to ensure that their ideas for change are considered, developed and tested.



The format of the Collaborative will be adapted from the traditional model (above) but will broadly consist of:

Learning Sessions: Face-to-face meetings bringing together multidisciplinary teams from across the organisation, along with those with expertise in both the subject matters and quality improvement to exchange ideas.

At the first Learning Session, the vision for ideal care in the topic area and specific changes, or Change Package, that when applied locally will improve significantly the system's performance.

Teams will learn the Model for Improvement that enables teams to test these powerful change ideas locally, and then reflect, learn, and refine these tests.

At the second and third Learning Sessions there will be an emphasis on the "All teach, all learn" principle. Team members learn even more from one another as they report on successes, barriers, and lessons learned in general sessions, workshops, storyboard presentations, and informal dialogue and exchange.

Formal academic knowledge is bolstered by the practical voices of peers who can say, "I had the same problem; let me tell you how I solved it."

Action Periods: During Action Periods between the Learning Sessions, teams test and implement changes in their local settings and collect data to measure the impact of the changes. They submit monthly progress reports for the entire Collaborative to review, and are supported by personal improvement support and other less formal meetings that enable them to share information and learn from experts and other people working on the same issues. The aim is to build collaboration and support the teams as they try out new ideas, without disrupting the service.

The Back to Basics (B2B) Collaborative is currently in a 'pre-work' phase with an aim to establish the first learning session in February 2018.

Structure

The B2B programme has established a Steering Group membership of which is primarily work stream leads and other allied health professionals. Other subject matter experts will be co-opted to the group as required. It is proposed that the B2B Steering Group reports to the NHS Borders Clinical Governance Committee in March, July and November 2018.

Workstream	**Lead**
Food, fluid and nutrition	Nicky Berry
Falls	Diane Keddie
Pressure damage	Erica Reid
Communication with patients and families	Peter Lerpiniere
Deteriorating patient	Annabel Howell

These leads will develop their work streams along the same lines:

- Develop strategy coordinated with B2B Steering Group and other work streams, developed and delivered by a sub group of the steering group
- Develop overarching policy and guidance, simultaneously retiring or refreshing the current documents
- Develop a package of improvement interventions and measurement plan
- Articulate the theory or rationale for changes
- Learn by testing changes sequentially
- Learning during scale up and spread with a production plan to go to scale
- Undertake periodic review
- Develop people to oversee and manage the system at micro and meso levels
- Contribute to the communication of progress for B2B

- Report on progress through the B2B Steering Group to the Clinical Governance Committee

Enablers
Preparing our staff to achieve these aims with our patients will require reviewing and building capacity and capability across a range of geographical areas, clinical specialisms to support more subject matter knowledge in the work streams above and in some cases basic care delivery requirements.

The B2B Steering Group has identified that the area of biggest risk in staff development is outdated IV therapy skills. This has therefore been prioritised as the first area to develop a comprehensive and realistic training programme.

To this end one of the urgent requirements is that 50% of relevant staff will be trained or retrained in IV Therapy mandatory training as risk assessed by their line manager by 31 January 2018. This will be achieved through completion of a Numeracy Assessment and Objective Structured Clinical Examination in the preparation of an IV antibiotic; on a one-to-one basis, observed by an impartial examiner.

Another that 100% of appropriate staff will complete MUST training by December 2017, in BGH. Across NHS Borders 100% will achieve this by 31st March 2018.

A new model of Critical Care Outreach provision supported by Acute Illness Management (AIM) trained staff across the organisation will be developed by March 2018.

Improvement work in other clinical areas will continue and be acknowledged within the B2B programme. The DME effect, or #endPJparalysis is one improvement project that is about to commence. This type of project will be monitored to ensure that there is not overwhelming pressure to any one clinical area and those successful improvement interventions are acknowledged and spread.

Other improvements, such as the new model of bed management will remove the bleep holding requirement of SCNs so releasing time to enable their participation in the B2B improvement programme.

Finally a new approach to quality assurance has been tested and is now being implemented across NHS Borders – the Person Centred Coaching Tool (PCCT). This is a new approach to care assurance where SCNs and CNs are taking 5 opportunities per week to coach their staff on good record keeping and care planning. This is giving our staff the opportunity to work closely with our expert nurses to ensure that high standards are maintained.

Developing our people
Skills & Knowledge: A fundamental nursing B2B clinical skills programme has been developed to support compliance with mandatory clinical skills standards. To accommodate local economies of scale, and fully prepare new clinical staff entering the organisation; this clinical skills education has now been aligned to the corporate induction programme.

There has been no healthcare support worker education for several years. A one day programme is being designed to meet the requirements of their role. This is a significant organisational challenge and modelling is already underway to scope and model a realistic training delivery plan.

Reporting of training requirements will transition in the coming months with the roll out of the Course Booking System Scorecard. This aggregates training needs across the organisation from personal learning plans. The Scorecard will significantly improve organisational learning & development reporting, providing a level of detail, accuracy and timeliness not previously possible.

Leadership Development
Each Senior Charge Nurse who is responsible for a ward area in acute, community and mental health will be invited to a Leadership Development Programme. This will be delivered through both local and national expertise. The core themes that will be covered during this six month programme are:

- Self awareness and leadership styles
- Leading effective teams, covering coaching and psychological safety
- Delivering excellent patient experience through learning and responding to feedback
- Enabling Professionalism

Communication strategy
One of the drivers for the B2B Programme was the unannounced inspection by Healthcare Improvement Scotland in June 2017, the purpose of which was to review the nutritional care of patients at the BGH. The resulting report and the improvements required which were detailed within it were published in September, are in the public domain and generated a significant amount of local and national media interest.

The B2B programme has already been announced both internally and externally as one of the Board's responses to the inspection, and regular communication about this clinical need for change – with both internal and external audiences is vital. The communications team will work with the B2B steering group to develop a comprehensive strategy to ensure that staff understand the direction and have an opportunity to shape the improvement interventions required, as well as shaping communications, as appropriate, with patients, the public and other stakeholder groups.

Excellence in Care (EiC)
The Cabinet Secretary for Health, Wellbeing and Sport has asked the Chief Nursing Officer and executive nurse directors to roll out Excellence in Care across Scotland.

Excellence in Care, which forms part of the Government's response to the Vale of Leven Hospital Inquiry Report, focuses on four key deliverables. It covers nursing and midwifery in all hospitals and community services, from A&E to mental health, and care of older people to children's services.

The aim is that all NHS boards and integrated joint boards will have consistent and robust processes and systems for measuring, assuring and reporting on the quality of nursing and midwifery care and practice in place by April 2018. The systems will inform quality of care reviews at national and local level and drive continuous improvements in nursing and midwifery care quality.

Excellence in Care Deliverables
Excellence in Care aims to deliver: • a nationally agreed (small) set of clearly defined key measures/indicators of high-quality nursing and midwifery • a design of local and national infrastructure, including an agreed national framework and "dashboard" • a framework document that outlines key principles/guidance to NHS boards and integrated joint boards on development and implementation of local care assurance systems/processes • a set of NHSScotland record-keeping standards.

NHS Borders B2B Collaborative is completely aligned with the aspirations and expectations of the EiC initiative as well as the ongoing requirements of the Scottish Patient Safety Programme.

EiC measures are currently in development along with a national reporting framework – Care Assurance Improvement Resource (CAIR). This system is being developed by Information Services Division (ISD) to support EiC to provide quantitative evidence of appropriate nursing care.

Financial Implications

Reduction of harm is a key measure of quality. The impact of this is often underestimated from the perspective of not just the patient but families, carers and staff. This can include the ripple effect. For example, fracture of neck of femur, which has a significant impact on a persons' physical, psychological and social wellbeing. This also imposes an estimated financial burden of £40,000.

Another example is the daily cost of treating a pressure ulcer which is estimated to range from £43 to £374. For ulcers without complications the daily cost ranges from between £43 to £57. These costs assume that patients are cared for in a hospital or long-term care setting but are not admitted solely for the care of a pressure ulcer. These are the daily costs in addition to the costs of standard care. Resources required include nurse time, dressings, antibiotics, diagnostic tests and pressure redistributing devices.[1]

Clearly there will be opportunity costs in the delivery of this approach to improvement. These will primarily be related to staff training and service maintenance when staff must be released to receive essential training or refresher training. Wherever possible we will attempt to minimise this by using an Objective Structured Clinical Examination style approach wherever possible in the patient care environment.

Costs are obviously impacted by poor quality. Rework, delay and redesign often presenting as patient dissatisfaction by means of complaints or adverse events reflecting harm caused. Similarly there are costs associated with good quality. Quality planning, quality improvement support and quality assurance all require resource.

At this time these costs cannot be quantified as such but close financial monitoring is already in place to ensure that costs are contained while we commence this improvement work.

[1] https://www.nice.org.uk/guidance/cg179/resources/costing-statement-pdf-248688109

Recommendation

The Board is asked to **note** this paper and **endorse** the approach to quality improvement outlined and to receive update reports from the B2B Steering Group via the Clinical Governance Committee minutes.

Policy/Strategy Implications	The NHS Scotland Healthcare Quality Strategy (2010) and NHS Borders Corporate Objectives guide this report.
Consultation	The content has been discussed at Clinical Boards and Clinical Board Governance Groups, the Clinical Executive Operational Group and to the Board Clinical & Public Governance Committees.
Consultation with Professional Committees	As above
Risk Assessment	In compliance as required
Compliance with Board Policy requirements on Equality and Diversity	Yes
Resource/Staffing Implications	Services and activities provided within agreed resource and staffing parameters.

Approved by

Name	**Designation**	**Name**	**Designation**
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