Borders NHS Board

Meeting Date: 7 March 2019

Approved by:	Cliff Sharp, Medical Director
Author:	Elaine Cockburn, Head of Clinical Governance & Quality

CLINICAL GOVERNANCE & QUALITY UPDATE MARCH 2019

Purpose of Report:

The purpose of this report is to provide an exception report to the Board from Clinical Governance & Quality.

Recommendations:

The Board is asked to **note** the report.

Approval Pathways:

This exception report has been prepared by Elaine Cockburn and approved by Cliff Sharp.

Executive Summary:

This is the second exception report prepared for the NHS Borders Board following agreement in November 2018 that only 2 detailed reports would be submitted each year. Areas covered within this report are:-

Patient Safety

- Hospital Standardised Mortality Ratio (HSMR) publication 12th February 2019 for Quarter 2, 2018/19
- Public launch of ZERO HERO campaign improving awareness of pressure ulcer prevention
- Duty of Candour

Person-centred health and care

- Feedback and complaints

CG&Q team capacity

Impact of item/issues on:

Strategic Context	The NHS Scotland Healthcare Quality Strategy (2010) and NHS Borders Corporate Objectives guide this report
Patient Safety/Clinical Impact	Patient safety, person-centred care and quality sit within the Clinical Governance & Quality portfolio
Staffing/Workforce	Services and activities are provided within agreed resources and staffing parameters

Finance/Resources	None
Risk Implications	In compliance as required
Equality and Diversity	Compliant
Consultation	The content is reported to Clinical Boards, Clinical Governance Groups, the Clinical Executive Operational Group and to the Board Clinical and Public Governance Committees.
Glossary	

Patient Safety

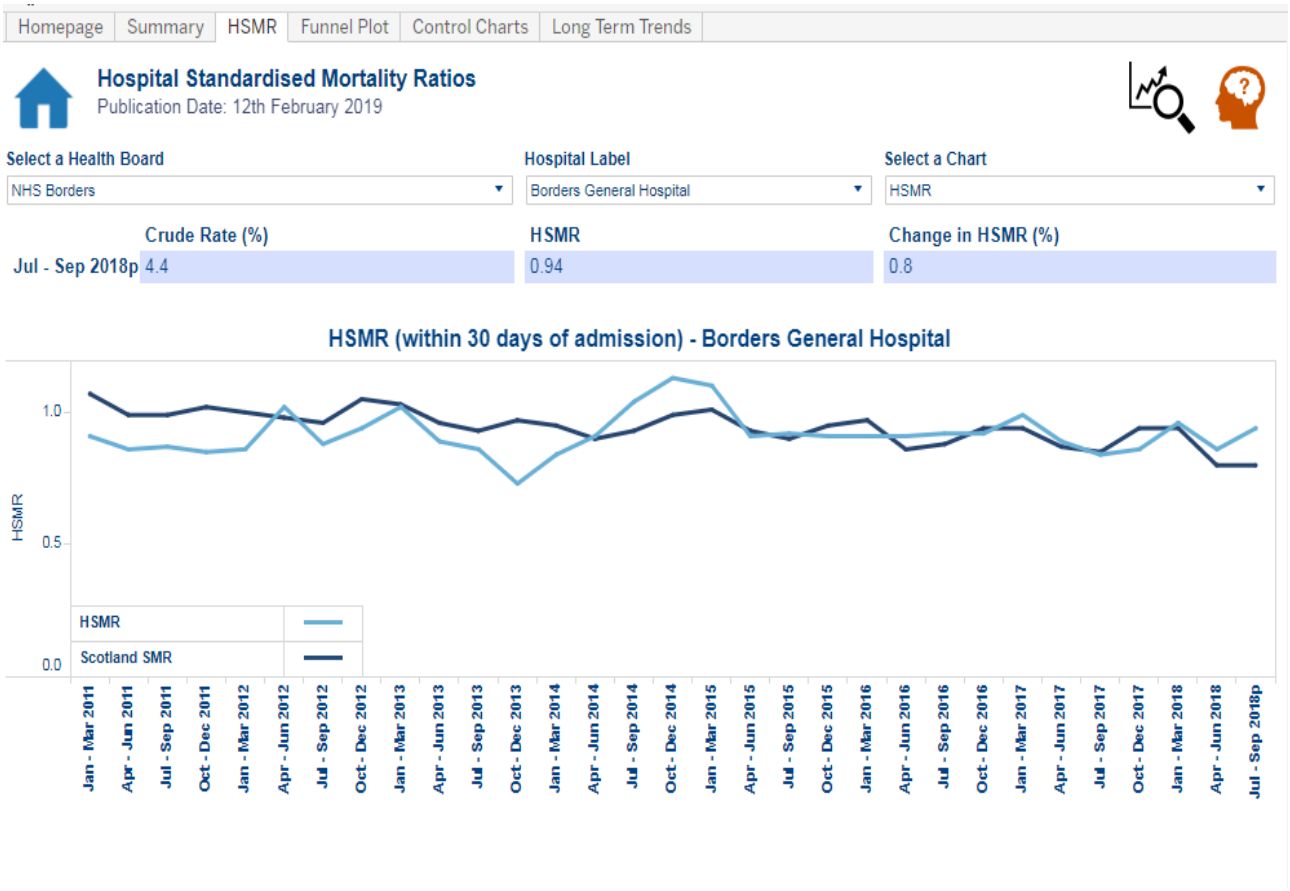
Hospital Standardised Mortality Ratios (HSMR)

HSMR is based on all inpatient and day case patients admitted to acute specialities in hospital. The calculation takes account of patients who died within 30 days of admission and includes deaths that occurred in the community as well as those occurring in hospitals.

The latest statistics reflect completeness of validated Scottish Morbidity Rates (SMR01) returns to Information Services Division (ISD) as at 11th January 2019. Published data is provisional at this time and is subsequently amended in the next national quarterly report to take account of returns received after the 11th January. There is usually only 0.01- 0.02 of a difference.

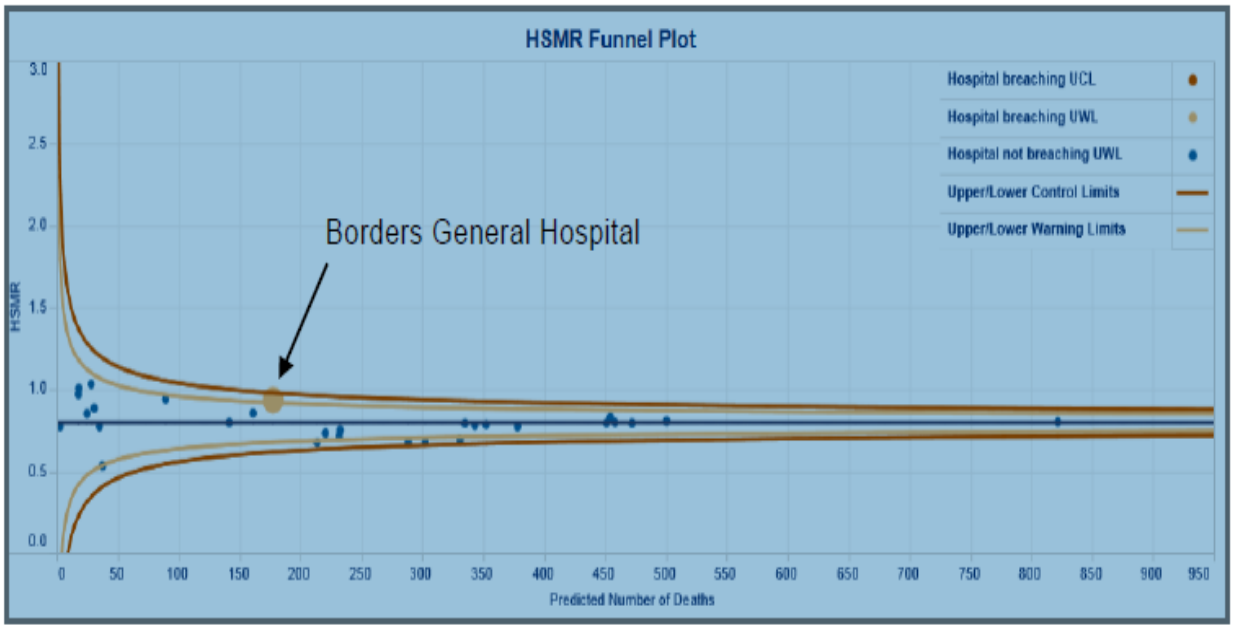
There are two areas within the report which shine a spotlight on NHS Borders' performance in this reporting quarter (Q2 2018/19):

- The funnel plot for NHS Borders demonstrates we are an outlier above the upper warning limit (UWL)
- NHS Borders is between 2 and 3 standard deviations above the Scottish HSMR



Hospital Standardised Mortality Ratio: release for July to September 2018[p].

Analyses for Borders General Hospital.



National picture

- HSMR at a Scotland level has decreased by 13.2% between January – March 2014 (first quarter of new baseline) and July-September 2018
- For the period July – September 2018 (Q2) there were no hospitals with a significantly higher standardised mortality ratio than the national average
- NHS Dumfries and Galloway, the nearest comparator to NHS Borders, had a HSMR of 0.73
- The mean HSMR for Scotland between January 2011- September 2018 is 0.92
- The HSMR across Scotland for Q2 was 0.80

NHS Borders performance

- NHS Borders' HSMR in Q2, July – September 2018 was 0.94, compared to 0.86 in the previous quarter April – June 2018
- Deaths in the quarter July – September 2018 were 6% fewer than predicted
- NHS Borders' HSMR for the same quarter in 2017/18 was 0.84
- NHS Borders' is above its mean of 0.92 for the period January 2011- September 2018

Local context

- Changes in the provision of palliative and end-of-life care are not factored in to case mix adjustment by ISD therefore patients within the Margaret Kerr Unit (MKU) are included in NHS Borders' deaths

- Of the 166 deaths in this reporting period, 150 were inpatient deaths and 16 were deaths in community. Of those 150 deaths, 33 of those were within the MKU. In the previous quarter, there were 149 inpatient deaths of which 41 were in the MKU.

Summary

In discussion with the Medical Director and Associate Medical Director for Clinical Governance & Quality (CG&Q), it has been agreed that a case note review of the 117 deaths (excluding MKU) should be undertaken and we are currently identifying key individuals to do this. A review of cases will help to ascertain if anything was missed in these cases or if any learning can be gained.

The key reason for mortality reviews and morbidity and mortality (M&M) meetings is to provide assurance of high quality optimal care and improve on this on an ongoing basis. Each department within the Borders General Hospital (BGH) has varying ways of reviewing M&M and we are working towards streamlining this to improve consistency. However, we need to ensure that any process put in place works for the teams involved. We know that to achieve optimum learning from previous events and make improvements we need to ensure a multidisciplinary approach and share the learning more widely across the hospital. There is currently no specific time allocated within job planning or administration time which takes account of the need to have regular reflective multidisciplinary meetings to review cases and share learning. This may need to be reviewed in future.

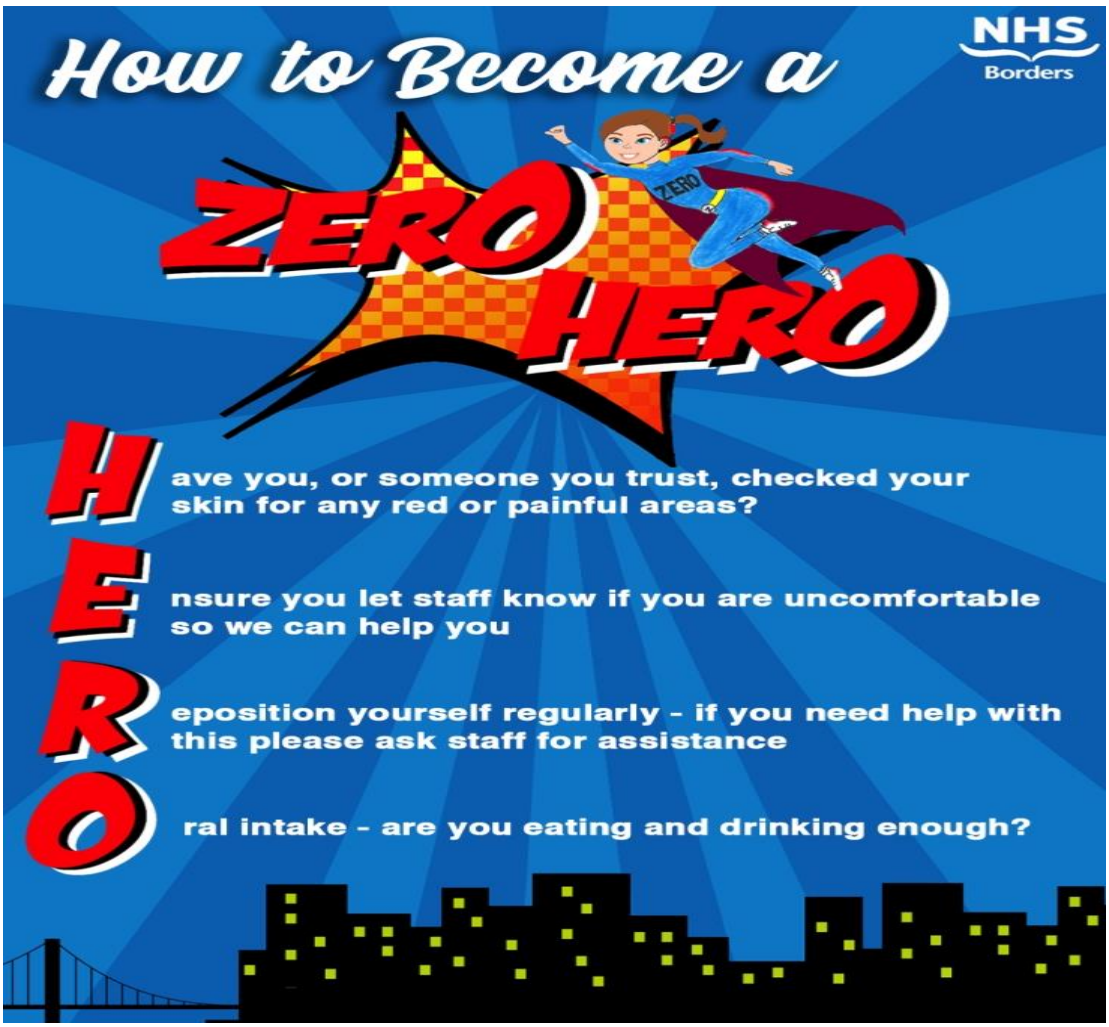
Healthcare Improvement Scotland (HIS) wrote to NHS Borders' Medical Director on the 6th February highlighting our data to make the organisation aware in order that appropriate action could be taken. A review of the deaths in quarter 2 had already been discussed and agreed prior to receiving this letter. Whilst our HSMR of 0.94 had not triggered any special cause and can be considered normal variation, a decision to review relevant cases was considered appropriate.

Our governance leads are in the process of setting up a M&M review panel in line with the Scottish Morbidity and Mortality Programme which will meet quarterly and share key learning points with the support of the Clinical Governance & Quality team.

Pressure ulcer prevention – public launch of ZERO HERO campaign

The public launch of the NHS Borders Zero Hero campaign took place on Monday 11th February. A stand with leaflets and posters was displayed at the foot of the stairwell in Borders General Hospital and Katherine Rolland, Tissue Viability Nurse Specialist was present to interact with patients, visitors and staff to improve awareness about pressure ulcer prevention.

Four key actions in the acronym HERO have been identified as a prompt for patients to help them reduce pressure damage and these are displayed in the poster below:



As part of the campaign, eye catching posters and information leaflets have been introduced to advise patients about how to prevent pressure ulcers, highlighting risk factors and what to expect from NHS Borders staff whilst in our care. These resources run in parallel with our staff-focused strand of the campaign which was launched in November 2018.

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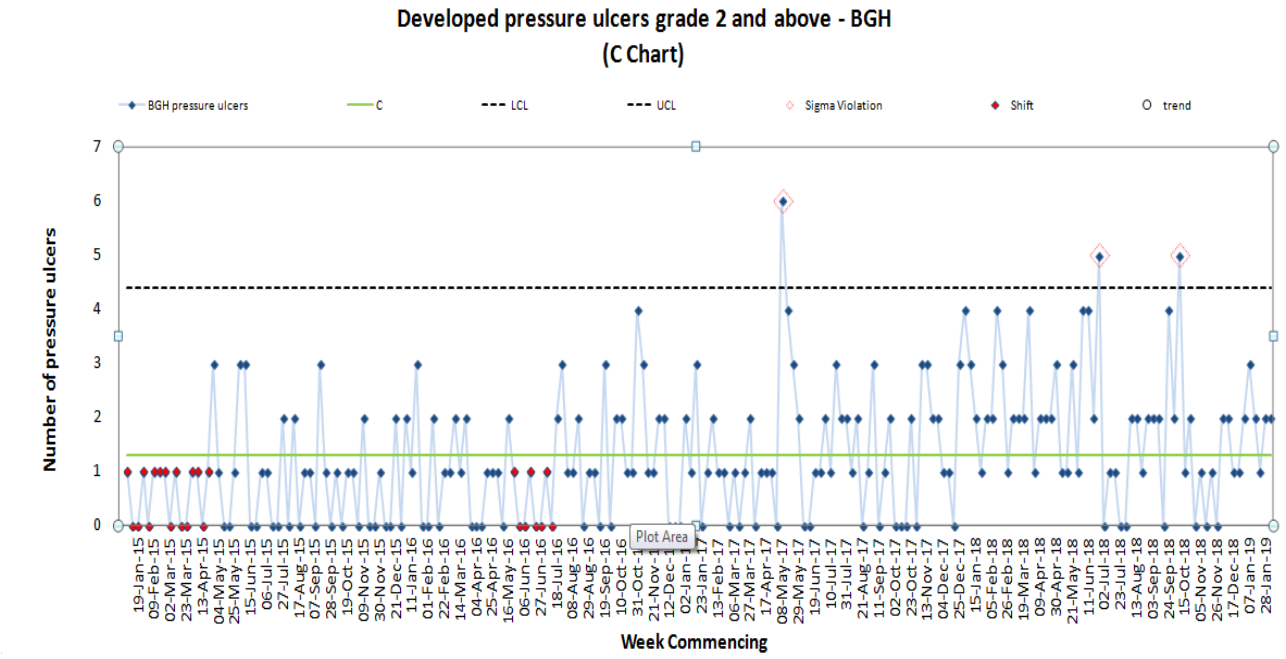
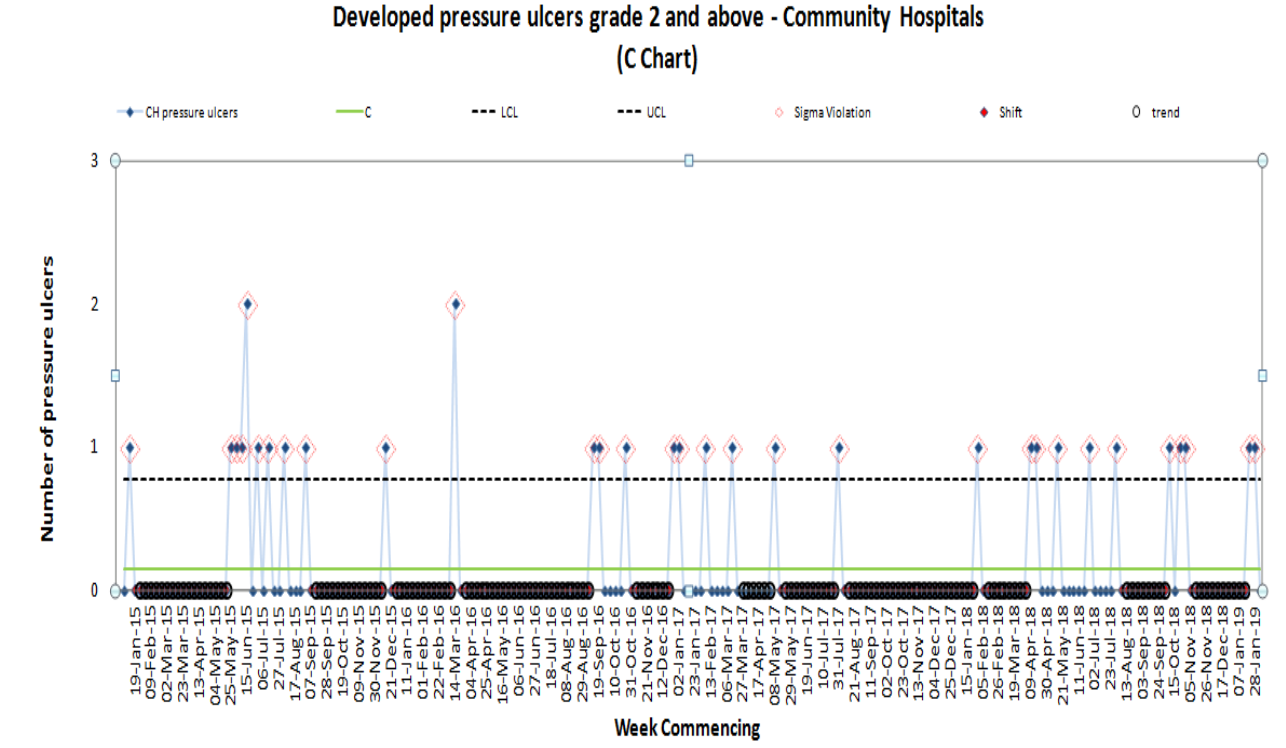
The actions in our staff HERO campaign run hand- in- hand with the actions in our pubic strand to ensure they are both aligned to avoid pressure ulcer development. Pressure ulcer prevention is a priority for NHS Borders as part of the Back to Basics programme which focuses on the fundamentals of patient care. Since the appointment of a tissue viability nurse, regular staff training has been delivered which includes grading of pressure ulcers, would care, completion of paperwork such as risk assessments and use of equipment.

A full audit has also been completed on pressure relieving equipment which has resulted in an investment in specialist equipment including cushions, mattresses and heel protecting boots to ensure appropriate equipment is available for our patients.

Kelso Community Hospital recently celebrated 365 days with no developed pressure ulcers and we look forward to more milestones such as this as our ZERO HERO campaign gains momentum.





The introduction of the staff training programme and patient information leaflets ensure compliance with Standard 2 of the Healthcare Improvement Scotland: Prevention and Management of Pressure Ulcers Standards- September 2016 which support the Older People in Acute Hospitals (OPAH) quality assurance programme.

Duty of Candour (DoC)

The duty of candour provisions within the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill were given Royal Assent on 6 April 2016. The implementation of duty of candour provision came into effect 1 April 2018.

While the principles of candour exist within many organisations and professional codes of conduct, the overriding purpose of the duty is to ensure organisations are open honest and supportive when there is an unexpected or unintended event that results in death or harm to an individual. This is expected of health, care and social work staff. The Act introduces a statutory organisational duty of candour on health, care and social work services.

Organisations have a requirement to publish an annual report on when the duty has been applied. These reports will cover the number of incidents, how the organisations have implemented the duty and what learning and improvements have been put in place. Reports require to be published on the organisations' website by the end of March. NHS Borders' information is currently being reviewed in order that a report can be written and published.

Person centred health and care

The CG&Q Board paper from January 2019 highlighted a spike in complaints in October 2018. An analysis of these has been undertaken and there were no wards, departments or staff groups that appeared to be outliers contributing to the spike.

An analysis of commendations has been considered and apart from being able to analyse themes from Care Opinion, it is difficult to glean further information currently from wards and departments as commendations are received by CG&Q via a count rather than letters or cards. The Quality Improvement Facilitator for person centred care is planning to meet with NHS Borders' Non-Executive Director Fiona Sanford to consider how to improve collating positive information across the organisation. This would help better balance what is received in relation to complaints as we know anecdotally, far more commendations are received compared to complaints. It would also be beneficial for staff to see that balance better portrayed. Some of the comments posted on Care Opinion have been gathered in a word cloud below. This represents how story sharers responded when asked 'how do you feel?'

Clinical Governance & Quality team

The CG&Q team are currently experiencing capacity issues due to a number of vacancies which have proved difficult to recruit to, compounded by sickness/absence across the team. There are challenges across all teams within the department. Ongoing recruitment is underway to ensure team capacity and capability return to a level where we can deliver all of our business as usual and business critical reporting. The team are looking at the potential for hybrid roles moving forward to improve team resilience to support better cross cover within teams and to consider how we better support quality improvement in the future.