Inverclyde council

NHS Greater Glasgow and Clyde

Report To:	**Community Health & Care Partnership Sub-Committee**	**Date: 28 April 2011**
Report By:	**Robert Murphy Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/23/2011/LB/CW**
Contact Officer:	**Dr Lawrence Bidwell Clinical Director Inverclyde Community Health & Care Partnership**	**Contact No: 01475 715376**
Subject:	**Clinical Governance Annual Report 2010 /11**	

1.0 PURPOSE

1.1 To present the 2010 /11 Clinical Governance Annual Report to the CHCP Sub-Committee.

2.0 SUMMARY

2.1 Health services have historically been required to report annually on clinical governance activity within the CHP.

2.2 This is the first such report which has been produced under the auspices of the CHCP. Consequently clinical governance activity requires to be reported not only to the NHSGGC Board but to the Local Authority in the form of the CHCP Sub-Committee.

3.0 RECOMMENDATION

3.1 The CHCP Sub-Committee is asked note the content of this report.

**Robert Murphy
Corporate Director
Inverclyde Community Health & Care
Partnership**

INVERCLYDE CHCP CLINICAL GOVERNANCE ANNUAL REPORT 2010 / 11

1.   Introduction

This Annual Report builds on the two previous Annual Reports. The fundamental geographic and demographic parameters of Inverclyde have not changed since these reports. However, the establishment of Inverclyde Community Health & Care Partnership anticipated in the last report to take place in April 2010 was ultimately established in October 2010.

2.   Service Scope / Context

2.1   The advent of the CHCP affords the opportunity to provide an integrated approach to primary care and social work services for the population of the Inverclyde Council area. The population of approximately 82,000 are located in the three coastal towns of Greenock, Port Glasgow and Gourock and a number of smaller communities. The range of services provided by Inverclyde CHCP includes Health & Community Care, Children & Families, Mental Health, Learning Disabilities, Addictions, Planning, Health Improvement, Commissioning, Criminal Justice, and Homelessness. General Medical, General Dental, Optometry and Pharmacy Services are provided by independent contractors.

2.2   Inverclyde CHCP hosts the Clinical Governance arrangements for the Clyde Challenging Behaviour & Rehabilitation Service (CBR).

2.3   Inverclyde continues to face significant social, economic and public health challenges. The later being evidenced by our work on mental health prevalence and also the recent Scottish Public Health Observatory (ScotPHO) Health & Wellbeing Profiles 2010 for Inverclyde.

3.   Clinical Governance Arrangements

3.1   Inverclyde Clinical Governance Group is chaired by the CHCP Clinical Director and meets bi-monthly. Membership includes Heads of Service and Professional Leads, staff from the Clinical Governance Support Unit are in attendance. Details of the membership and terms of reference are attached (Appendix 1).

3.2   Reporting arrangements are through the Professional Executive Group (PEG) to the CHCP Committee and ultimately to NHSGGC and Inverclyde Council.

3.3   There are also links through the NHSGGC Clinical Governance Forum to the NHSGGC Clinical Governance Implementation Group. There are also links to Boardwide clinical governance arrangements for Mental Health and Learning Disabilities.

3.4 Governance arrangements for social work functions have traditionally been exercised through the line management structure. The recent establishment of the CHCP and the involvement of social work staff in key posts with regard to clinical governance afford the opportunity for this historic pattern of social work governance to be reviewed.

3.5 At each Clinical Governance meeting the following areas of activity are considered:

- Patient Safety / Clinical Risk
  - Infection Control
  - Datix
  - Clinical Governance Workplans
  - Critical Incident Reviews
  - Prescribing / Medication Issues
  - Risk Register
- Complaints
  - Ombudsman Reports
- Clinical Effectiveness
  - Effectiveness Workplan
  - National Guidance
  - Clinical Governance Bulletins
- Child Protection
- Adult Protection
- JIQAAG (Joint Inverclyde Quality Advice and Assurance Group)
- Health & Safety
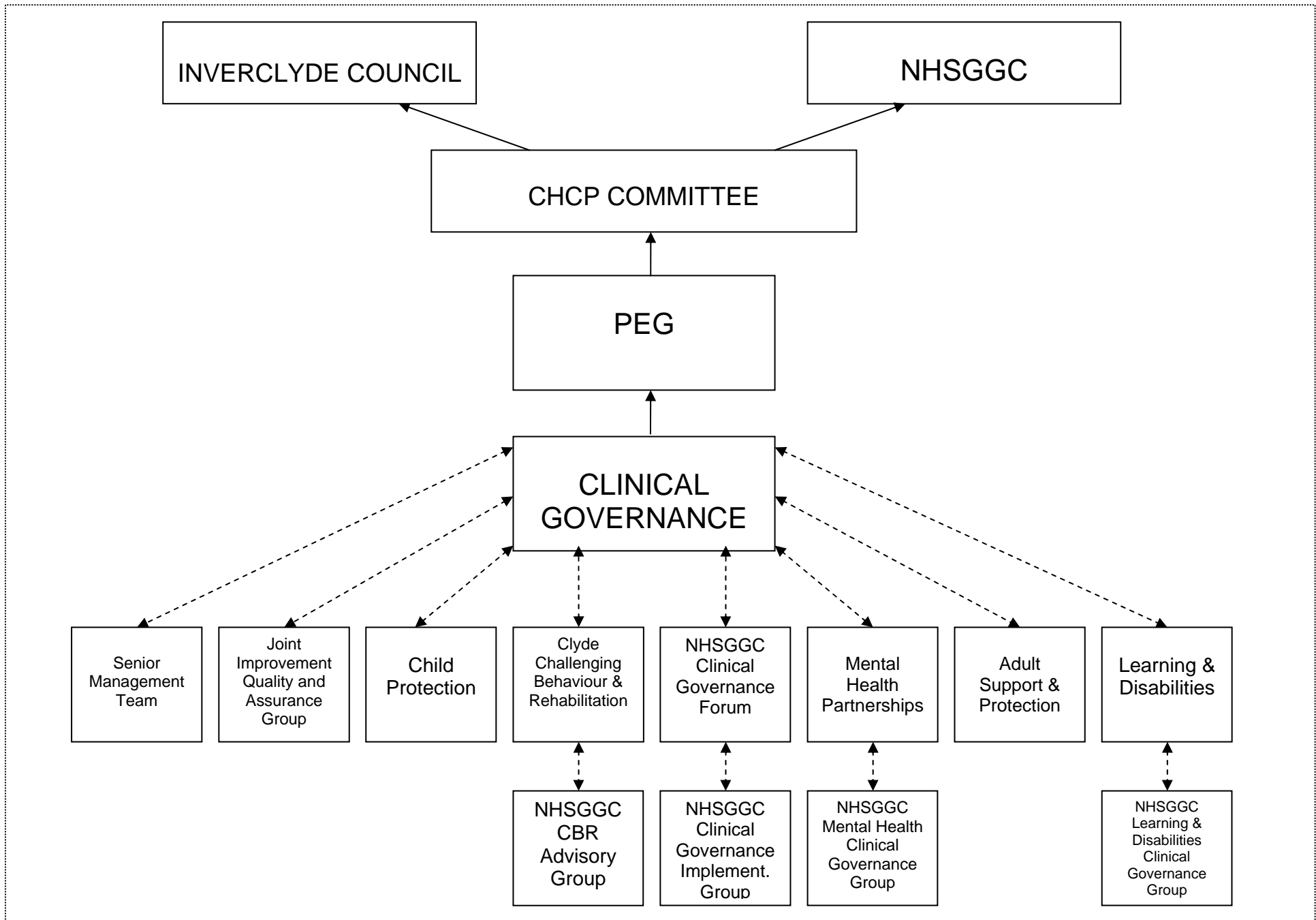
4. Patient Safety

4.1 The Clinical Governance Group routinely reviews the CHCP and individual service Risk Registers, Incidents and Complaints Activities in order to identify learning in opportunities with the objective of improving patient safety. The Datix system is increasingly being used to record this clinical governance data and steps are being taken within the CHCP to promote the use of data output from Datix within the individual service teams. Safe prescribing and use of medication are significant patient safety issues, examples of work undertaken in this area in the last year include:

4.1.1 The completion of work in relation to a LES focusing on patients on long term antidepressants. This pilot work showed that a small though not insignificant cohort of these patients could benefit from review resulting in either change, reduction or alternative forms of treatment. An action plan has been developed and it is hoped that some form of local quality marker for long term antidepressant prescribing can be agreed with General Practitioners as a consequence.

4.1.2 The multidisciplinary review of apparently anomalous anti-psychotic prescribing referred to in the previous annual report has been completed. This work has demonstrated that when the prevalence of mental illness was taken into account the rate of anti-psychotic prescribing within Inverclyde CHCP area is broadly in line with that of the rest of the Board area.

4.1.3 In the light of a National Patient Safety Agency (NPSA) document on safer use of Methotrexate and ongoing board-wide concerns regarding prescribing and monitoring of this medication, an audit of the use of Methotrexate has been undertaken across the CHCP. The audit was designed to highlight a range of safety issues including dosage discrepancies, blood monitoring arrangements, mixed tablet strengths, excess quantities and omission of folic acid. 265 patients on Methotrexate across the CHCP were included in the audit. The actions taken following the audit include:

- Number of patients - Methotrexate inactivated as no longer taking – 14.

- Number of patients – 10mg tablet strength changed to 2.5mg – 9.

- Number of patients where dose +/- frequency instructions changed – 20.

- Number of patients whose quantity was changed to 4 weeks or less – 18.
- Number of patients started/restarted on folic acid – 8.

- Number of patients called for blood monitoring as a result of the audit – 20

A supply of NPSA Methotrexate patient information and blood monitoring booklets has been distributed to all GP practices, and a second cycle of audit is currently being undertaken.

4.1.4 The CHCP has within the last year been the lead organisation for 2 Critical Incident Reviews (CIR), the second of which is currently ongoing. This work, in compliance with the recently published revised CIR policy may, have significant patient safety implications. The first CIR briefing highlighted the importance of formal record keeping which has been proposed throughout the CHCP

5. Clinical Quality Improvement / Clinical Effectiveness

5.1 The following are a few examples if Clinical Quality Assurance / Clinical Effectiveness activities within the CHCP. Appendix 2 provides a fuller list of the activities.

5.1.1 Older Peoples Mental Health - Healthcare Acquired Infection (HAI)

Hospital Acquired Infection (HAI) Scribe & Infection Control Audits both highlighted the overall poor state of in-patient accommodation and within the elderly psychiatric continuing care wards in particular. This provided irrefutable evidence and leverage leading to long outstanding repairs and replacements finally being funded and acted upon by the Estates Department.

5.1.2 Learning Disabilities – Cancer and Bowel Screening

In 2004 a Health Needs Assessment for people with Learning Disabilities included information on the high risk people with Learning Disabilities are at of developing GI cancers. Inverclyde Community Learning & Disability Team (CLDT) in partnership with Health Improvement ran a training session for formal and informal carers to support the national bowel screening campaign. It is hoped this will result in carers being more aware and confident to support people with Learning Disabilities uptake on cancer screening programmes.

5.1.3 Antidepressant Review

This project has worked constructively towards addressing the antidepressant HEAT target by supporting practices to appropriately review patients prescribed antidepressants. This project has supported practitioners and patients to optimise antidepressant use by continuing, reducing, stopping, increasing and switching if needed.

Based on 649 antidepressants prescribed for this cohort (624) of patients that attended for follow up of review of antidepressants:

Change in Defined Daily Doses (DDDs)

- 6.1% reduction in DDD pre to post review for the CHCP.
- Statistically significant difference ($p < 0.01$), using two tailed t-test. demonstrates 39% power at 95% power confidence.

Change in Prescribing Costs

- 7.6% reduction in prescribed antidepressant costs per annum, pre to post review for the CHCP.

- Total Reduction of £4822.00

- Reduction of £305.12 per annum per practice.

- Reduction of £7.73 per patient per annum across the CHCP for this cohort.

5.1.4 <u>HMIe Inspection of Child Protection Services</u>

Following the HMIe Child Protection Inspection the summary findings are that the evaluations for the Inverclyde area are:

- Children are listened to and respected – Excellent
- Children are helped to keep safe – Very Good
- Response to immediate concerns – Very Good
- Meeting needs and reducing long term harm – Very Good
- Self evaluation – Very Good
- Improvements in performance – Very Good

There were no requirements or recommendations made in respect of Adoption or Fostering.

Two areas for improvement were identified and these are:

- Build on successful work already in place to support improved outcomes for vulnerable children and families.

- Continue to develop ways of monitoring and analysing data about Medical examinations to ensure children's health needs are being fully met.

Steps have already been taken to address recommendations.

5.1.5 <u>Podiatry</u>

HEAT Target – "Wait for 1st appointment will not exceed 9 weeks. New patient referrals are triaged based on level of urgency. A podiatric needs matrix and care pathways have been introduced initially for new patients. This has allowed a more focussed patient journey with the aim of supported discharge for those capable of looking after their own foot health.

6. Clinical Supervision and Staff Support

6.1 Heads of Service have ongoing processes in place for checking registration of established clinical staff and also new members of staff. There is an induction programme for new staff who are thereafter supported by a range of clinical supervision arrangements, including annual reviews, personal development plans and the KSF.

6.2 Should there be any concerns regarding clinical performance issues, mechanisms are in place ranging from support, addressing any educational or professional needs, through to more formal HR or professional regulatory responses dependent on the nature of the concerns.

6.3 There have been no areas of clinical underperformance in the CHCP in the last year.

7. Developing and Using Clinical Information

7.1 Considerable work has been done with SPARRA Data in relation to 16 patients aged less than 14 years.

7.2 Comparison of this data set with those held on Health Visiting, District Nursing (Continuum) and Social Work (SWIFT) systems. Concordance across these data sets was noticeably poor. Ultimately the 16 cases were reviewed by a local Consultant Paediatrician and significant potential improvements in clinical information and management were identified between Specialist Services and the Community Children's Nursing Team (CCNT) in Inverclyde.

7.3 SPARRA data has also been extensively analysed in conjunction with acute colleagues in relation to its value as a predictive tool in relation to Accident & Emergency attendance. As a result of this work a significant cohort of patients have been identified who have the potential to attend A & E either with direct or in-direct consequences of alcohol consumption. Work with alcohol and addiction colleague's shows a significant proportion of these patients are known to their service and work is currently underway to assess the feasibility of a direct referral to these services from A & E hopefully addressing HEAT Target 3242.

7.4 As stated in the previous Clinical Governance Report there was significant local concern regarding the apparent local utilisation of SCI for referral purposes. Considerable work has been carried out involving local General Practices, Inverclyde Royal Medical Records staff and the SCI referral team resulting in a number of process deficiencies and anomalies being identified in both secondary and primary care. These have been addressed by the process of information sharing and training resulting in a consequent improvement in Inverclyde's reported SCI referral data.

7.5 6 practices in Inverclyde have participated in Wave 4 of the Keep Well Project. Despite some of the practice experiencing significant challenges with the tracking tool considerable progress has been made.

7.6 14 Gpass using practice in Inverclyde are currently in the midst of transition to the recommended EMIS system.

8. Brief update of an uni-disciplinary strategies or initiative with major focus on improving the quality of care e.g. implantation of Delivering Care and

Enabling Heath (the National Strategy for Nursing and AHPs)

8.1   The Tall Ships Race will be visiting Greenock in early July 2011. Inverclyde CHCP has provided an arena for several health agencies and planners to consider the implications of this event both in terms of provision of health services to the crews and site visitors and also from the perspective of maintaining services for the local population. Working with the events company has initially proved challenging though recent meetings have improved communications and hopefully this will be reflected in better planning outcomes. Health Improvement staff are now actively engaged in preparations for this event.

9.   Conclusion

9.1   This year has been a significant period of change for primary care with the establishment of the CHCP. Maintenance of clinical governance throughout this period of change has been paramount and hopefully reflected in this report, which can only reflect a flavour of the clinical governance activity undertaken during the last year. The attached workplans provide greater details and are attached at Clinical Effectiveness Workplan (Appendix 2) and Clinical Governance Annual Workplan (Appendix 3).

Appendix 1 CHCP Clinical Governance Group TOR
Appendix 2 CHCP Clinical Effectiveness Workplan
Appendix 3 CHCP Clinical Governance Workplan

Appendix 1

Inverclyde council

NHS Greater Glasgow and Clyde

<u>**Inverclyde CHP Professional Executive Group**</u>

<u>**Clinical Governance Group**</u>

<u>**Terms of Reference**</u>

1. **Purpose**

   This paper proposes the establishment of a Clinical Governance Group to the Inverclyde CHP Professional Executive Group (PEG).

   This group will have CHP-wide responsibility for establishing a coherent and co-ordinated clinical governance framework with a related action plan and supporting communication arrangements.

   The Group will report to the Professional Executive Group and be chaired by the designated CHP Lead Clinician for Clinical Governance.

2. **Context**

   The CHP has responsibility for the management and co-ordination of a broad range of NHS services. In addition, the CHP has significant 'partner' relationships with Acute services, the Mental Health Partnership and with Inverclyde Council. The CHP clinical governance framework needs to take account of all of these interfaces to allow the CHP to have a comprehensive set of arrangements for clinical governance.

   The CHP Professional Executive Group will meet in April 2008 to formally confirm that this Group is established and to agree terms of reference.

3. **Clinical Governance Group of the PEG**

   Thereafter it is proposed that a Clinical Governance Group of the CHPs Professional Executive Group is formed. This group will replace any pre-existing LHCC Clinical Governance groups/arrangements.

   The remit of this Group will be to:

   - establish a comprehensive clinical governance framework and work programme for the CHP in line with the Greater Glasgow & Clyde NHS Board priorities
   - through this ensure a systematic approach to quality improvement within existing services including arrangements for learning from complaints
   - ensure that the CHP establishes appropriate risk registers, consistent with the NHS Greater Glasgow & Clyde risk strategy
   - establish agreed procedures and systems for major critical incident review and ensure arrangements are in place for learning from such reviews to be applied
   - encourage and support staff to participate in clinical audit where

- encourage and support independent contractors and their staff to participate in clinical audit where appropriate
- ensure the application of agreed clinical protocols and guidelines and contribute where necessary to the development of such protocols and guidelines
- ensure arrangements are in place for the implementation of agreed medicine management changes and systems (links to lead prescribing role/Prescribing Forum of the PEG)
- ensure arrangements are in place for the appraisal for all medical staff, including revalidation, undergraduate and post graduate medical education and training as required
- ensure that arrangements are in place for services to be organised and delivered that are culturally competent and fair for all and ensure that we assess the impact of future service plans on all service users
- ensure that the benefits realisation from the new GMS Contract are clear and that related contract monitoring is in place and that these link to the clinical governance programme, processes and outputs
- to inform, and where necessary, contribute to staff training and development, including educational and peer review meetings and other protected learning time
- contribute to the CHP-wide organisational development work programme and processes, building on the nine transformational themes shaping the NHS Greater Glasgow & Clyde single system working arrangements.

4. Membership

The table below sets out the proposed membership of the Clinical Governance Group.

Role / Representative	Name
CHCP Clinical Director	Dr Lawrence Bidwell
CHCP Prescribing Lead	TBC
CHCP Administration Manager	Jeanette Hawthorn
Children's Nursing / Adult Nursing	Fiona van der Meer / TBC
Allied Health Professional x 3	Elizabeth McGloin / Sharon Lafferty / Hazel Young
Community Optometrist	TBC
Community Pharmacist	TBC
Community General Dental Practitioner	TBC
Consultant Paediatrician	Dr Brain Kelly
Consultant Psychiatrist	Dr James Loudon
Consultant EMI	TBC
CLDT	Alan Best
Senior Health Improvement Officer	Jan Graham
Clinical Governance Lead – South Clyde MPH	Margaret Aitken
General Practitioners x 1	TBC
Lead Social Work	TBC
Lead Clinical Pharmacist	Margaret Maskrey
Staff Partnership Representative	Angela Thomlinson

Role/Representative	Name

Practice Nurse	TBC
Practice Manager	TBC
Senior Infection Control Nurse	Maureen Stride

In Attendance

Head of Health & Community Care	Brian Moore
Head Mental Health, Addictions & Homelessness	Susanna McCorry-Rice
Head of Planning, Health Improvement & Commissioning	Helen Watson
Head of Children's Services & Criminal Justice	Sharon McAlees
Lead Health & Safety	Sean Wright, H&S Advisor
Clinical Risk Co-ordinator	Lynnette Cameron
Learning & Development Adviser	TBC
Complaints Manager	Pamela McCamley
Clinical Governance Facilitator	Philip O'Hare

5. Meeting Cycle

It is proposed that the Clinical Governance Group of the PEG meets on a bi-monthly basis.

6. Reporting Arrangements

Agendas and notes from Group meetings will be reported to each subsequent PEG meeting for information, actions noted and discussed as required.

The Clinical Governance Group will be required to produce by April of each year a work programme for the year ahead, indicating where possible work programme issues and priorities that are longer term (each year up to three years ahead). The Group will also be asked to produce an annual report on progress; this report will inform the work programme for the year ahead.

Inverclyde CHCP Clinical Effectiveness Workplan: 2010-2011

Project	Lead	Main areas of focus/good practice points	Patient Involvement	Start Date	End Date	Status	Changes/Improvements as a result of the project
Primary Care Mental Health Post Evaluation	Elaine Corcorran	A project to evaluate the effectiveness of a school-assigned mental health worker.	Yes	Oct 2010	Feb 2010	Report in draft stages	
ADHD Medication Study	Dr Anam Hamoudi	An audit into ADHD medication which aims to monitor client compliance and satisfaction of service. It will also assess the impact of ADHD on family life.	No	Feb 2009	Early 2011.	Data analysed. AH preparing final report.	
GP Evaluation of Antidepressant Review	Hector MacDonald Pauline Kay	To obtain GP experiences of the AD Review project.	Yes		Jan 2011	Complete. Report available.	This project has worked constructively towards addressing the antidepressant HEAT target by supporting practices to appropriately review patients prescribed antidepressants. This project has supported Practitioners and patients to optimise antidepressant use by continuing, reducing, stopping, increasing and switching if needed. The majority of patients continued their current antidepressant and dose. The reviews may improve concordance as patients are better informed. It has provided an opportunity for Practices to review non-formulary antidepressants medicines use: dosulepin and escitalopram.
Evaluation of services provided by the Diabetes Specialist Nurse	Doreen Kennedy	To identify areas of good practice and to investigate avenues in which the service can be improved.	Yes	March 2010	Early 2011	Questionnaires distributed.	
Diabetes Treatment	Doreen Kennedy	To track changes to a patients HbA1C, Blood Pressure, Cholesterol and BMI in order to gauge successful diabetes treatment over a 12-18 month period. Drug side effects and referrals will also be tracked.	No	Dec 2010	July 2011	DK populating database.	

Projects not supported by the CGSU

Project	Lead	Main areas of focus/good practice points	Patient Involvement	Start Date	End Date	Status	Changes/Improvements as a result of the project
Communication Issues at the Primary/Secondary care interface.	Prescribing					Updates to be given at Governance Meeting on 9th February	
Audit of Methotrexate	Prescribing					Updates to be given at Governance Meeting on 9th February	
Macmillan Palliative Care Pharmacist Facilitator	Prescribing					Updates to be given at Governance Meeting on 9th February	

Projects led by Dr Bidwell (supported by Pauline Kay)

Project	Aim/Objective	Links to HEAT target / SIGN guideline / Professional Standards	Lead	Anticipated date (subject to change)	Current Status	Report Produced?	Changes/Improvements expected as a result of the project
SCI referrals Work conducted by the CHCP, with local GP Practices to investigate manual referrals with Medical Records, Information Services and SCI Delivery Team to improve current practice. Baseline month of October 2009 evidenced that 1631 referrals were generated, 289 (18%) were recorded as manual and 1342 (82%) as electronic.	Improve electronic referral rate (GP to consultant led care).	To support the achievement of HEAT target: To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are managed electronically to 90 per cent from December 2010.	Dr Lawrence Bidwell (supported by Pauline Kay)	By December 2011	November 2010 data evidences that there has been a slight increase in the number of manual referrals however overall referrals have reduced. The enclosed graph demonstrates that of 1558 referrals in November, 156 (10.01%) were recorded as manual and 1402 (89.99%) as electronic. S:\Inverclyde CHP\ Clinical Director\Clinic	Update provided via the Clinical Improvement steering group report	Improvements in the rate of electronic referrals.

Project	Aim/Objective	Links to HEAT target / SIGN guideline / Professional Standards	Lead	Anticipated date (subject to change)	Current Status	Report Produced?	Changes/Improvements expected as a result of the project
Work has been ongoing to implement a formal procedure for GP Practices to notify appropriate services and medical records at IRH of known deaths.	To improve communication of deaths between Primary and Secondary care.	Good Practice /Improving interface between Primary/Secondary Care	Dr Lawrence Bidwell (supported by Pauline Kay)	September 2011	Database developed to record notification of death. One local Practice will pilot the tool to determine effectiveness.	Update provided via the Clinical Improvement steering group.	The final proposed format will be shared with the Local Medical Council for approval prior to roll out locally to the remainder of GP Practices. A standard approach for notification of death would ensure records are accurately maintained and that communication is improved between Primary and Secondary Care services.
Alcohol Services to identify living arrangements, reasons for admission, recurring health problems and support existing in those patients care.	Utilise SPARRA data to identify additional support/interventions for those patients (110) predicted with an alcohol admission.	Support the HEAT Target for A& E Attendances: To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E	Dr Lawrence Bidwell/Mandy Ferguson	December 2011	Alcohol Services completed a questionnaire (per client) to identify living arrangements, reasons for admission, recurring health problems and additional support amongst other details. Staff completed a questionnaire if any person had been discharged from their caseload within last 30 days.	Update provided via the SPARRA Project Group	Improvements in communication and referral systems/process from A&E. Note current opportunity to improve links through training for alcohol screening. Improvements in Discharge planning. Exploring if alcohol services play a greater role in discharge planning Non engagement with service/service refusal. Can services be more assertive in their attempts to engage high risk individuals?

Project	Aim/Objective	Links to HEAT target / SIGN guideline / Professional Standards	Lead	Anticipated date (subject to change)	Current Status	Report Produced?	Changes/Improvements expected as a result of the project
Utilise a sample of SPARRA Data (prediction of alcohol related admission ~ 91 patients) Medicals secretary to carry out a retrospective data capture exercise for this group of patient's attendance at A & E. Medicals secretary to complete a data capture form for any 'real time' attendances at A & E between 1st July 2010 – 31st December 2010	Validate SPARRA as a predictive tool for admission/re-admissions.	Support the HEAT Target for A& E Attendances: To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E	Dr Lawrence Bidwell/Karen Munro (supported by Pauline Kay)	December 2011	Medical secretary carried out a retrospective data capture exercise for this group of patient's attendance at A & E for the period between 1st January – 31st June 2010. Medical secretary completed a data capture form for 'real time' attendances at A & E between 1st July 2010 – 31st December 2010. Analysis shows that, out of 91 patients predicted to attend A&E between 1st January 2010 – 4th November 2010: • 6 of the 91 patients were deceased • 54 patients totalled to165 attendances at A&E • 32 of the totalled presentations were alcohol related • 1 of the presentations was drug related • 38pts contributed to 61 admissions • Those 61 admissions accounted for 327 bed days.	Update provided via the SPARRA Project Group	Finding evidence that SPARRA predictive tool is an accurate account for admission and re-admission. Discussion would take place with the wider A & E senior team regarding the possibility of flagging this cohort of patients on the hospital EDIS system and completing a data capture form for any attendances at A & E between 1st July 2010 – 31st December 2010
Introduction of MRI Knee Scans prior to refer to consultant.	To provide GPs with appropriate access within an algorithm for MRI knee scans.	Supporting the achievement of the HEAT Target RTT 18 week referral to treatment from 31 December 2011. Links to improving Primary/Secondary Care interface.	Dr Lawrence Bidwell	April 2011	Preparation work underway to commence pilot and initial briefing sessions organised to inform local clinicians.	Evaluation via the Clinical Improvement Steering Group	Appropriate referrals to Orthopaedics, GPs having access to MRI scans and results prior to consideration of referral for orthopaedic assessment will reduce and eliminate inappropriate referrals.

Project	Aim/Objective	Links to HEAT target / SIGN guideline / Professional Standards	Lead	Anticipated date (subject to change)	Current Status	Report Produced?	Changes/Improvements expected as a result of the project
Implementation of the Liverpool Care Pathway for the Dying Patient. (Auditing LCPs)	Reflective practice to be conducted by Practice and Community Nursing to identify areas of good practice, areas of improvement required.	Introducing a model of best practice. The LCP is recommended by the Department of Health as the best practice model for care of the dying in: Department of Health (2009) 'End of life Care Strategy: quality markers and measures for end of life care'. Department of Health (2008) 'End of Life Care Strategy promoting high quality care for all adults at the end of life'. Department of Health (2006) 'Our Health, Our Care, Our Say: a new direction for community services'.	Dr Lawrence Bidwell (supported by Pauline Kay)	June 2011	Local LCPs have been received from 10 Practices with 20 LCPs being audited. This has provided robust learning points for Practice and CHCP to review and reflect on practice. Practices provided with access to DNA CPR training materials which was a good practice area highlighted.	Via the Clinical Improvement Steering Group	Practices respecting patients wishes by implementing the DNA CPR documentation for appropriate patients. Sharing of good practice and implementing appropriate process and changes to improvement other areas highlighted for Palliative Care.

Project	Aim/Objective	Links to HEAT target / SIGN guideline / Professional Standards	Lead	Anticipated date (subject to change)	Current Status	Report Produced?	Changes/Improvements expected as a result of the project
Antidepressant review LES (prescribing)	Introduce a quality measure to GP Practices for antidepressant prescribing.	HEAT Target: Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10, and put in place the required support framework to achieve a 10 per cent reduction in future yrs. This target was replaced in April 2010 with an access to psychological therapies HEAT target which states: 'During 2010/11 the Scottish Government will work with NHS Boards to develop an access target for psychological therapies for inclusion in HEAT in 2011/12.' The CHCP will work with The Mental Health Collaborative (MHC) to will continue to focus on improving both evidence-based prescribing of antidepressants and improving access to non-drug treatments.	Dr Hector Macdonald (supported by Pauline Kay)	December 2011	Proposal being established to share at GP Forum in March. Invitation to Practices to participate will then commence.	Via the Clinical Improvement Steering Group & Mental Health Collaborative	Regular review of patients by GP prior to prescription for antidepressants. Consideration of referral to other support services /interventions prior to prescription for antidepressants.

Appendix 2

Specialist Children's Services

CHCP	Project Lead/ CE Support	Project Title	Project Aim	Pt Involved	Current Status
Child Protection	Marie Valente/Susan Harvey	Outcome evaluation of children referred from Health to Social Work	To assess and explore the outcomes for children where there are welfare concerns	No	Final report stage
Child Protection All CHCPs NHSGGC	Maria Valente/Susan Harvey	Systematic self evaluation of child protection services	To support CP committees NHSGGC wide to use the National Performance framework to evaluate their CP services and identify areas of improvement.	Yes	Three year rolling programme
CAMHS NHSGGC	Dr Eleanor Kerr	ADHD Patient Care Pathway	In response to SIGN 112 a group has been set up to develop a care pathway for ADHD patients.		
Acute and Partnerships NHSGGC	Laura Wiggins + physiotherapy staff, surgeons, OT staff/Susan Harvey	Multilevel surgery protocol	Pathway and Protocols for Children with Neurological conditions referred for Multilevel Orthopaedic Interventions		Guidance document being put together.
Inverclyde & Ren CAHMS	Dr Kathy Leighton	Audit based on HONOSCA study with local additions	To establish database for all CAMHS contacts for Inverclyde and Renfrewshire	No	Ongoing

CHCP Governance Committee Work Plan – Inverclyde CHCP (2010-2011)

		Objectives	Action	Lead/Support	Timescale	Current Progress
1.		**Clinical Risk Management**				
1.1		**Incident Management** Ensure that any associated actions following incidents are tracked and implemented across all services.	Confirm system is in place and operating effectively. Capture local actions/improvements in quarterly/annual report.	CD/HoS CD	June 2011	Principals of Quality Assurance agreed with Head Planning, Health Improvement and Commissioning.
1.2		To produce timely aggregated incident reports to the Governance Committee	Ensure all staff are aware of incident reporting arrangements within the CHCP. Quarterly reports to be produced and discussed at the GC to identify emerging trends, patterns, and issues for consideration. Tracking system to be established that will provide examples of issues considered and action taken.	CD/CRC CD/CRC	Ongoing	Regularly reviewed at Clinical Governance.
1.3		**Risk Register Policy** Ensure that the CHCP Risk Register is regularly maintained.	Ensure that the Risk Registers are transferred to the Datix Risk Register module. Ensure that the Risk Register is reviewed on a quarterly basis.	CD/HoS/CRC CD/HoS	Ongoing	Regularly reviewed at Clinical Governance.
1.4		**Medication Safety** To have a specific focus on medication safety to reduce the incidence of medication error. Demonstrate the use of incident reporting to investigate and reduce the incidence of		CD/PS/HoS	Ongoing	Regularly reviewed at Clinical Governance.

Leads		**Support Staff**	
HoS:	Heads of Service	CRC:	Clinical Risk Co-ordinator CGSU
PS:	Pharmacy Support	CEC:	Clinical Effectiveness Co-ordinator CGSU
LCS:	Local Complaints Support	PIF:	Patient Involvement Facilitator CGSU
L&EM:	Learning and Education Manager		
CD:	Clinical Director		
GC:	Governance Committee		

	Objectives	Action	Lead/Support	Timescale	Current Progress
	medication error and demonstrate learning. To have a dedicated focus on high risk medicines locally in the CHCP.				
1.5	**Rapid alerts** Maintain a database of nationally published alerts with details of local response	Establish a system for dissemination and tracking of responses.	HoS/CD	In Place	Regularly reviewed at Clinical Governance.
2.	**Complaints & Feedback**				
2.1	Ensure a robust system is in place for the management, processing and investigation of all complaints across the CHCP, which complies with national statutory directions, Scottish Government Health Department guidance and NHSGG & C central policy and/or guidance on the NHS Complaints Procedure.	Establish local complaints handling process. Ensure that information (leaflets, booklets, posters etc) on the Complaints Procedure is freely accessible/available to all patients, service users, patients' representatives etc across all CHCP sites/premises	HoS/CD	Ongoing	Follow established Boardwide Policies.
2.2	Ensure system is in place within the CHCP to monitor complaints activity and outcomes, to demonstrate learning and that complaints are used to inform service improvements.	Bi-monthly stats report to be produced for the Clinical Governance Group. Quarterly Complaints report on actions/learning points from completed complaints to be produced for the Clinical Governance Group. Establish a system to ensure actions arising from complaints are tracked and completed and to disseminate learning points and service improvements that arise from complaints.	HoS/CD	Ongoing	Follow established Boardwide Policies.
2.3	Continue to utilise the Datix Incident Surveillance System (Complaints Module)	Ensure that appropriate staff are trained in the use of Datix and that local process and procedures take account of the system	CD	Ongoing	Follow established Boardwide Policies.

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		Objectives	Action	Lead/Support	Timescale	Current Progress
2.4		Ensure all staff are familiar with the requirements of the NHS Complaints Procedure and that appropriate staff are adequately trained for the purposes of undertaking complaints investigations across the CHCP.	Procedure and protocols to be raised within local teams. All staff to be encouraged to access existing basic level induction training. Appropriate staff to access NHSGGC complaints training. Managers to ensure PDPs reflect development needs.	HoS	Ongoing	Reiterated at Clinical Governance Group, Senior Management Team and Extended Management Group.
2.5		Ensure mechanisms are in place to enable and utilise other forms of feedback from patients and/or service users. Ensure local processes are in place to deal with informal complaints or concerns raised locally.	Establish mechanisms to obtain alternative forms of feedback (e.g. surveys, suggestion boxes). Establish a process to collate and analyse information received via informal complaints or concerns, or other alternative forms of feedback. Establish process to use information received via informal complaints or concerns, or other alternative forms of feedback, to inform service improvement.	CD/HoS	Ongoing	Mechanisms are in place.
3.	**Clinical Effectiveness**					
3.1		Ensure that the Clinical Effectiveness Strategy & Framework is being implemented and priorities identified that lead to improvement in services. Ensure that each service area has a clinical effectiveness workplan in place	Develop a robust Clinical Effectiveness work plan that represents each of the services and reflects national and local priorities. Put a system in place to track the learning, action planning and impact on service improvements from the work plan. **Key priority areas** Primary and Secondary Care Interface - improving data/communication between primary and secondary care. Development of a scheme to capture data via	HoS/CD/CEC HoS/CD/CEC CD CD	March 2011 March 2011 Ongoing June 2011	Regularly reviewed. Achieved

	Objectives	Action	Lead/Support	Timescale	Current Progress
		A&E attendance in order to verify SPARRA as a predicting tool and to consider a more pro-active response from children services.			
3.2	Ensure national standards and guidelines are assessed, distributed and implemented.	National standards and guidance will be assessed and discussed at the Governance Committee for implementation as appropriate.	HoS/CEC	Ongoing	Discussed at Clinical Governance Group.
		The audit programme will have as a focus national standards and guidance to ensure best practice is being followed locally.	HoS/CEC	Ongoing	Clinical Effectiveness Co-ordinator is actively prioritising this project.
		To support the agreed programme of external visit for 2009/10 by NISH, Hemi, SWAIN.	HoS/CEC	Ongoing	Clinical Effectiveness Co-ordinator is actively prioritising this project.
		Review reports from external inspection visits and take forward actions as appropriate. ▪ Take forward actions from HMIe Visit	HoS	Ongoing	Via Clinical Governance Group and individual services.
3.3	Reduce Waiting Times	Monitor waiting times and take appropriate action as required.	HoS	Ongoing	Data and issues reviewed by CHCP Acute / Primary Care Interface Group.
3.4	To ensure that patient and carers are included in planning and reviewing service provision.	Undertake mapping of current arrangements and examples of activity involving users.	HoS/PIF	Ongoing	
		Implement NHSGG&C Consent Policy on Healthcare & Treatment and participate in the Board-wide audit.	HoS/CEC	September 20120	Completed
4.	**Staff Governance**				

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	Objectives	Action	Lead/Support	Timescale	Current Progress
4.1	Ensure that established systems are in place to meet professional registration requirements.	Confirm that professional registration of all staff is current.	HoS	Ongoing	
4.2	Ensure arrangements are in place for performance management and support for poor performance.	Confirm arrangements are in place.	HoS	Ongoing	
4.3	All staff should have an up to date job description, KSF outline and PDP.	Confirm arrangements are in place.	HoS	Ongoing	
4.4	CHCP should have a training plan which flows from service needs and PDPs.	Ensure training plan is available.	HoS/L&EM	Ongoing	
4.5	Ensure appropriate local induction arrangements are in place.	Assess current position and report back.	HoS/L&EM	Ongoing	
5.	**Reporting Mechanisms**				
5.1	Ensure that Clinical Governance arrangements are in place within each of the service areas.	Assess current arrangements and impact.	HoS / CD	Ongoing	Established working with Planning to link CHCP Development planning processes and promote Quality Assurance activity.
5.2	Establish Quarterly /Annual Clinical Governance reporting cycles.	Assess current arrangements and impact.	HoS	Ongoing	
6.	**Clinical Information**				
6.1	To develop and use clinical information to improve the quality of service.	To interrogate data sets drawn from existing information systems and provide examples of how this information has been used to improve services.	HoS/CEC	Ongoing	Progressing in several clinical areas.

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7.	**Learning & Education**				
7.1	Ensure process is in place to provide General Practitioners with Adult, Support & Protection (ASP) Training and Adults With Incapacity (AWI) Training.	Confirm arrangements are in place.	CD	March 2011	Completed.
7.2	Ensure process is in place to provide General Practitioners with Level 3, Child Protection Training	Confirm arrangements are in place.	CD	Ongoing	First cycle of training completed. Second cycle arranged for June 2011.

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