West Dunbartonshire
Community Health & Care Partnership

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Clinical Governance Annual Report 2011

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1 Introduction

Clinical governance is how health services are held accountable for the safety, quality and effectiveness of clinical care delivered to patients. Clinical governance is a statutory requirement of NHS Boards and is achieved by coordinating three interlinking strands of work:

- Robust national and local systems and structures that help identify, implement and report on quality improvement.
- Quality improvement work involving health care staff, patients and the public.
- Establishing a supportive, inclusive learning culture for improvement.

The CHCP Director has overall accountability for clinical governance within the CHCP and for those clinical services that the CHCP directly manages or directly contracts for. This is primarily discharged through CHCP's Clinical Director (who is a practicing GP) and the CHCP's Heads of Service. The Clinical Governance Group is a sub-group of the SMT, composed of the Clinical Director (as Chair) and Heads of Service plus the CHCP Lead Pharmacist and now the MSK Physiotherapy Service Manager. The Group is supported by the Clinical Risk Co-ordinator and Clinical Effectiveness Co-ordinator from the NHSGGC Clinical Governance Support Unit.

The CHCP's annual Clinical Governance Workplan explicitly reflects the three 'quality ambitions' as outlined in the NHS Quality Improvement Scotland paper on developing a 'quality strategy programme in primary care', i.e.:

- Person centred
- Safe
- Effective

Clinical effectiveness is about using the best available research evidence together with clinical expertise and patient involvement, in order to provide the best possible care for patients. (NHSGG&C. *Clinical effectiveness framework 2007.*) The CHCP is committed to scrutinising services to provide public assurance about the quality and safety of that care (as per NHS Scotland *Assuring Person-Centred, Safe and Effective Care: Clinical Governance and Risk Management 2011*). Our aim is to involve frontline clinicians and senior management in the work, ensuring unstifled, widespread generation of ideas, alongside recognition that our work legitimately has national and health board direction. This annual report then provides an overview of the progress and achievements made in relation to that agreed workplan for the year 2011 (as per NHSGGC requirements). These have been taken forward as an integral element of the CHCP's previous *Strategic Plan 2011/12* (which also details the scope of the CHCP's responsibilities and commitments across the totality of its services).

This is the first CG Annual Report for West Dunbartonshire prepared under the auspices of the CHCP's now established integrated management arrangements for health and social care. The aim of the CG Workplan described here naturally has a clinical health care focus – but it does recognise those aspects of social care that overlap with our ability to produce improved quality of care for the population of West Dunbartonshire; and the discussions within the CG Group through this past year have increasingly recognised the importance of the CHCP expressing a singular and over-arching ethos of care governance across all staff and services. A good example of the relevance of this was a Significant Case Review, commissioned by the local Child Protection Committee (CPC – chaired by the CHCP's Head of Children's Health, Care and Criminal Justice who is also the Council's Chief Social Work Officer), into the circumstances surrounding an incident where a young child drank methadone. There are a number of actions as a result of the findings of the review, not just for local implementation but others that been highlighted at national level.This incident provides an example of a social care quality matter that was also of concern to the NHS' clinical governance arrangements – and importantly, where our local integrated senior management arrangements ensured a joined-up and consistent response to the local actions identified.

Against the backdrop of embedding those integrated managerial arrangements and accompanying operational service development, the local CHCP's approach to clinical governance demonstrates an impressive enthusiasm of all staff striving to deliver better quality clinical care. The cohesive manner in which all services come together to do this for patients is both reassuring and refreshing in these challenging times.

Dr Kevin Fellows
CHCP Clinical Director

March 2012

2 Context

West Dunbartonshire lies north of the River Clyde and encompasses the urban communities of Clydebank, Dumbarton, Balloch, Alexandria and Renton. There is also a more rural area that runs south of Loch Lomond. The population of West Dunbartonshire is estimated at 90,920 (table 1). In West Dunbartonshire the trend has been for the number of deaths to be greater than the number of births; and for out-migration levels to exceed in-migration.

Table 1 (West Dunbartonshire Social and Economic Profile 2009-2010)

Age Bands	Number of Females	% Females	Number of Males	% Males	Total Persons	% Total
0-4	2,611	5.5%	2.728	6.3%	5,339	5.9%
5-9	2,352	4.9%	2,356	5.5	4,708	5.2%
10-14	2,505	5.2%	2,681	6.2%	5,186	5.7%
15-19	2,849	6.0%	3,080	7.1%	5,929	6.5%
20-24	3,100	6.5%	3,262	7.6%	6,362	7.0%
25-29	2,982	6.2%	2,928	6.8%	5,910	5.4%
30-34	2,591	5.4%	2,336	5.4%	4,927	5.4%
35-39	3,047	6.4%	2,671	6.2%	5,718	6.3%
40-44	3,752	7.9%	3,321	7.7%	7,073	7.8%
45-49	3,772	7.9%	3.375	7.8%	7,147	7.9%
50-54	3,486	7.3%	3,121	7.2%	6,607	7.3%
55-59	2,954	6.2%	2,733	6.4%	5,687	6.3%
60-64	2,864	6.0%	2,685	6.2%	5,549	6.1%
65-69	2,370	5.0%	1,892	4.4%	4,262	4.7%
70-74	2,081	4.4%	1,621	3.85	3,702	4.1%
75-79	1,897	4.0%	1,207	2.8%	3,104	3.4%
80-84	1,319	2.8%	716	1.7%	2,035	2.2%
85-89	823	1.7%	314	1.0%	1,137	1.3%
90+	403	0.8%	135	0.3%	538	0.6%
Total	**47,758**		**43,162**		**90,920**	

According to the Scottish Index of Multiple Deprivation (SIMD) 2009, West Dunbartonshire has 33 datazones in the 15% most income deprived category. Half the datazones in West Dunbartonshire are in the 30% most deprived on the overall SIMD with similar patterns showing in the income, employment, health and crime domains. The more deprived datazones in West Dunbartonshire are concentrated in the South East and the West of the area.

The health needs of the local population are reflected in the following reports:

- *West Dunbartonshire Social and Economic Profile 2009-2010*
- *2010 Health and Wellbeing Profile for West Dunbartonshire*
- *2010 Children and Young People Health and Wellbeing Profile for West Dunbartonshire*
- *2011 Mental Health and Wellbeing Profile for West Dunbartonshire*
- The West Dunbartonshire Community Planning Partnership -sponsored *Health and Wellbeing Survey of West Dunbartonshire's 15% SIMD Areas.*

West Dunbartonshire Community Health and Care Partnership (CHCP) brings together both NHS Greater Glasgow and Clyde's (NHSGGC) and West Dunbartonshire Council's (WDC) separate responsibilities for community-based health and social care services within a single, integrated structure (while retaining clear individual agency accountability for statutory functions, resources and employment issues). West Dunbartonshire CHCP leads and manages a substantial range of NHS and Council Services. Its Schemes of Establishment sets its stated aims as being to:

- Improve the health of the population.
- Contribute to closing the inequalities gap.
- Promote Social Welfare for the population of West Dunbartonshire.
- Share governance and accountability between NHSGGC and WDC.
- Have substantial responsibility and influence in the deployment of NHS and Council resources.
- Manage local NHS and social care service.
- Play a major role in Community Planning.
- Achieve better specialist care for its population.
- Achieve strong local accountability through the formal roles for lead councillors and the engagement and involvement of its community.
- Drive NHS and Local Authority planning processes.
- Protect and support vulnerable children and adults in the community.
- Deliver services that are of good quality and value for money.
- Make access to our services easier.
- Promote an understanding of Social Work within the wider community.
- Have a competent, confident and valued work force.

In addition to local services provided for and with the residents of West Dunbartonshire, the CHCP has formal responsibilities for a number of wider geographic functions:

- NHSGGC Community Eye Care Service.
- NHSGGC Musculoskeletal (MSK) Physiotherapy Service (from 1st April 2012).
- Management of Argyll, Bute and Dunbartonshire's Criminal Justice Social Work Partnership.

The CHCP also has a number of formal Service Level Agreements in place with the neighbouring Argyll and Bute Community Health Partnership in relation to services that have mutually agreed as being sensibly provided across the boundaries of our respective geographic boundaries (all of which are subject to regular review).

It should be noted that the clinical governance accountabilities for the NHSGGC Community Eye Care and MSK Physiotherapy Service are the managerial responsibility of the CHCP – and so inform the agenda of the CHCP's Clinical Governance Group. Correspondingly, the clinical governance responsibilities for other locally provided clinical services that are managerially

"hosted" by other entities of NHSGGC lie with those respective entities. In addition, the clinical governance responsibilities for individual local external NHS contractors (general practice, community optometrists, community pharmacists and general dental practice) primarily rests with each contractor themselves – however, NHSGGC have an interest in and responsibility for the quality of clinical care provided by all those NHS contractors not least as part of the contract monitoring arrangements in place for each; and the CHCP has an interest and commitment to working with local NHS contractors to deliver our shared commitment to high quality clinical care for the patients and communities of West Dunbartonshire.

3 Patient Safety

Patient Safety is about the reduction and prevention of harm that may be experienced by patients during their care. Patient safety is a core priority for individual CHCP operational service plans. Heads of Service have risk registers which they review within their services and bring to the clinical governance group where they are reviewed alongside the CHCP Risk Register. From there, the CHCP Risk Register goes to SMT for the Director to formally review and agree.

The CHCP uses the Datix system of incident reporting and in 2009 adopted the on-line Datix system. Managers are also trained in RCA for investigation of incidents. The GP practices submit Significant Event Analysis (SEAs) as part of the national Quality and Outcomes Framework (QOF) and the Clinical Director brings learning points to the CG Group; and where appropriate shares through the CHCP Professional Advisory Group (PAG) and the local primary care locality groups.

National safety improvement in primary care programme (sipc)

In 2010, the Health Foundation awarded funding to deliver two discrete Safety Improvement in Primary Care projects, SIPC1 and SIPC2, in Scotland, to test aspects of safety improvement within primary care and at the interface between primary and secondary care. At present the development of Patient Safety Programme for Primary Care is being informed by the learning from SIPC1 and SIPC2 and a National Launch of the Patient Safety Programme in Primary Care is scheduled for March 2013.

NHS Greater Glasgow & Clyde are taking forward a programme in Primary Care that will include the following topics:-

- Safer Medicines
  - Disease-modifying anti-rheumatic drugs (DMARDS)
  - Insulin Management

- Safe and Reliable Care across the Interface
  - Medicines Reconciliation
  - Implement care bundles for Heart Disease (LVSD)
  - Prevention of Pressure Ulcers

- Develop practice teams safety culture
- Using the Safety Climate Survey

Two West Dunbartonshire GP practices - Dr Bell and Partners and Levenside Medical Practice - have been recruited to the programme, to explore different aspects of patient safety and share learning, which will inform the development of the National Patient Safety in Primary Care Programme. The participants will become skilled in general improvement methodology for identifying, reporting and reducing harm in primary care. They will develop knowledge of quality improvement methodologies and create a patient safety culture using:-

- Small tests of change - plan do study act (PDSA)
- Reliable methodology bundles of care
- Process mapping

This programme is being piloted until July 2012.

4 Clinical Supervision and Staff Support

As defined by NHSGGC, the CHCP has 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 NHS Knowledge and Skills Framework (KSF).

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.

5 Developing and Using Clinical Information

Clinical information is used in various ways to develop and support good practice. For example, detailed prescribing data is used to identify trends in prescribing, particularly outliers and Quality Markers.

When reviewing practice performance, various practice activities in relation to the Quality Outcome framework, Immunisation and Screening targets (e.g. cervical or colorectal health screening) are tools to trigger review and support when and where appropriate.

In line with the SCI-DC (Scottish Care Information-Diabetes Collaboration) Diabetes action plan: Quality care for diabetes, all podiatry clinics now have access to SCI-DC, enabling an allocated foot risk stratification score to be electronically communicated to healthcare professionals involved in the care of the patient.

6. Complaints:

There were 14 formal NHS complaints received and concluded during 2011. Of these, we could not respond to the detail of one complaint because patient consent had not been received and of the 13 complaints responded to, eight were considered to be fully or partially upheld. The learning has been extracted from these upheld complaints and would have been shared within / across services had this been appropriate. However it is clear from these that learning has been local and has not required any wider, system wide consideration. There have been no trends generally and given the relatively low incidence of formal complaint across services, it is difficult to identify any particular trend. Also, it is not unusual to see a higher incidence of complaint in mental health services given the nature of the service. It should be noted that there have been some instances where issues raised in this manner have been managed clinically and not through the formal complaints process.

In terms of response times, 12 of these 14 complaints received their response within 20 days, the other 2 being outwith the 20 days response target. This gives an overall 12 of 14 responses within target i.e. some 86% against the 70% target.

The table of NHS West Dunbartonshire CHCP complaints received within the year 2011 – 1st January to 31st December 2011, may be viewed in Appendix 4.

7. Challenges in the Future

Looking to the year ahead, the CHCP is looking to promote the roll-out of the national patient safety programme in primary care, paying particular attention to the work undertaken by the two local GP practices (Dr Bell & Partners and Levenside Medical Practice) participating in the NHSGGC pilot workstream to explore different aspects of patient safety and share learning. The CHCP will also further strengthen its clinical governance arrangements in relation to and support for those NHSGGC-wide clinical services that the CHCP “hosts”, namely the established Eye Care Service and the MSK Physiotherapy Service. Even though the latter is a new arrangement from the 1st April 2012, clinical governance priorities have already been established, most notably a NHSGGC wide audit to evaluate the impact of physiotherapy - pre and post intervention - on patients’ pain, functions of daily life and work status.

Work will also continue to further capitalise on opportunities afforded by the integrated management arrangements of the CHCP to support effective and joined-up clinical governance, including establishing a single incident reporting system across all CHCP services, with clear feedback loops to ensure lessons learned are put into everyday practice. A notable innovation has been the development of a single CHCP strategic risk register across its health and social care responsibilities which goes “live” in April 2012.

The CHCP will also be subject to a routine comprehensive inspection by the Care Inspectorate through a large portion of 2012. While this process will still

reflect a traditional focus on social care provision and professional social work practice, it will hopefully recognise those aspects of clinical health care that overlap with our ability to produce improved quality of care for the population of West Dunbartonshire; and the Senior Management Team's commitment to expressing a singular and over-arching ethos of care governance across all staff and services.

West Dunbartonshire CHCP has applied the clinical governance principles of person centred, safe and effective patient care to all the patient services in the CHCP. In a year that has seen a number of changes in the CHCP organisation and personnel, the CG activities demonstrate an impressive enthusiasm of all staff, striving to deliver better quality care. The cohesive manner in which all services come together to do this for patients is both reassuring and refreshing in these challenging times.

Appendix 1 Clinical Governance Work Plan

High Quality Health care

Key Drivers	Quality Ambitions	Priority Areas	Theme	Service	Project
Person-centred	Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making	1. **Complaints & Feedback-** Learning and improvement 2. **Increase PPF representation-** 3. **Communication-** Sharing learning and CG outputs 4.**People/staff governance** 5**. Better Together Survey actions**	1pc 2pc 3pc 4pc 5pc 6pc 7pc 8pc 9pc 10pc	CMHT PCMHT Mental Health Pharmacy Children's Health Visitors Health Visitors DNurses COPT Podiatry **All Staff**	The advice clinic Audit Evaluation of users views Access to Psychological Services Visual Impairment Resource Rainbow room evaluations Parents views on Parenting handbook Antenatal home visits, vulnerable mothers Living and dying well Evaluation of client centred goals User experience of nail surgery Staff annual have individualised PDPs
Safe	There will be no avoidable injury or harm to people from healthcare, advice or support they receive, and an appropriate clean and safe environment will be provided for delivery of healthcare services at all times	1. **Incident Management-** Themes, Learning and action plan 2**. Risk Register** Review and escalate Risks 3. **Health Care Associated Infection-** 4. **Health and Safety-** Safety action notices 5. **Professional registration, Clinical Support and registration**	1s 2s 3s 4s 5s 6s 7s	Pharmacy Pharmacy Pharmacy DNurses Mental Health Mental Health Pharmacy **All services** **All services** **All services** **All services** **All clinicians** **All clinicians**	Warfarin INR Monitoring Methotrexate prescribing Audit Baseline medication issues, hospital admission COPD Management LTC Adult support and protection Complete review of clinical incident system Hospital medication discharge anomalies log of all clinical incidents on Datix Maintenance and management of Risk Registers Monthly incident reports Eksf related PDP monitoring Monitor updating of annual registrations Clinical supervision
Effective	The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated	1**.Programe of Clinic Audit** 2. **Service Evaluation Activity** 3**. Use of existing datasets for QI-** Complaints,CIR, IT systems 4. **Guidelines**- Review & implementation of Guidelines & standards 5. **Research and development**	1e 2e 3e 4e 5e 6e 7e 8e	HV& SN HV School Nurse Podiatry Physio COPT Mental Health Health Imprv. **All services**	HMIe Inspection SHANARRI assessment tool Record keeping audit Toe Nail surgery Audit Physiotherapy Tinetti interventions Local Autism Strategy Suicide prevention training programme Clinical Governance related guidelines review

West Dunbartonshire-specific Clinical Effectiveness Projects

- (2pc) PCMHT. User Evaluation of advice clinic: To develop an effective regular feedback of reported user issues which may be rapidly addressed? To offer service user's the opportunity to express their views and experience of the care journey within the advice clinic. Over 97% rated quality of service good. 75.6% of users happy of with time waited for appointment. Nearly 97% satisfied with support offered by the advice clinic. *"It was very good even though it was my first appointment. I feel a little better and more positive already". "The clinic gave me the chance for the first time to speak of all my experiences. Have never felt at ease enough to do this before"*

- (6e) An ongoing mental health project: To implement a local Autism Spectrum Disorder Strategy. Strategy and Approach ensuring application of referral pathways and awareness of access route to service. Clear Referral Pathways. Ongoing Joint Training to dedicated Diagnostic Interview for Social and Communication Disorders (DISCO) trained staff. Currently a Sub Group Established to implement the autism service

- (3pc) An ongoing mental health project: To increase access to population based psychological therapies. A HEAT target to implement a co-ordinated approach for assess to Psychological Services across Primary /Secondary and the Third Sector. Currently a Sub Group Formed and discussion paper produced by Dr Matt Wilding to implementation.

- (5s) An ongoing mental health project: To Implement Adult Support and Protection (ASP) across WD CHCP. The planned outcomes of which will be all partners have access to and attend ASP Training. All ASP cases are reported and directed to the appropriate agency. To date the West Dunbartonshire have over 400 staff trained across CHCP

- (7e) Health Improvement project to Increase in the number of staff trained in: "Safetalk", "Assist", and "Storm". The standard is that all staff will be educated and trained in suicide prevention programme. 71% of Frontline Staff currently trained to an appropriate Level. Mike Foley, Rose Stewart Choose Life Co-ordinator

- (4pc) Prescribing Support Pharmacists project to improve the medication-related experience of visually impaired (VI) residents of WD. In October 2009 West Dunbartonshire CHCP was approached by members of a local group – Focus - an umbrella organisation for vision impaired people (VIP) in West Dunbartonshire. Focus outlined some of the difficulties encountered by VIP the safe use of prescribed medications. A number of actions were taken immediately, and the idea of producing a resource that would enable pharmacists to help this vulnerable group of patients to use and take their medicines safely was discussed and agreed. A multi-disciplinary, multi-agency steering group, including service users was brought together to develop the proposed resource. In April 2011, a resource - "Let's see if we can help" - was launched. It has two elements: A written guide of "hints and tips", with sections on ways to help people take their medicines, labelling and identification of medicines, and links to further information; and a pack containing samples of

stickers, pictograms, and aids such as bump-ons, together with information about stockists. Development of the resource included talking to relevant service users about the difficulties they face in taking their medication, and methods they use to make it easier. The experiences of service users were also sought as part of the evaluation of the resource. A short life working group involving some members of the original steering group is supporting the continued dissemination of the resource, which has aroused interest from a range of health professionals in diverse settings and areas. This project supported by Margaret Black, patient involvement facilitator, CGSU and Pamela McIntyre, prescribing support pharmacist lead.

- (1s) Prescribing Support Pharmacists project: To ensure all patients dispensed Warfarin are receiving Warfarin monitoring. Phase two report indicated 74% of patients dispensed warfarin through their CPs in WD had been asked if they were receiving INR monitoring by their CP. Results show great 45% improvement in number of patients being receiving INR monitoring. Final report due April 2012

- (3s) Another Prescribing Support Pharmacists projects looking a baseline audit of medication issues identified which result or contribute to patients being admitted to hospital with ultimate goal of improving the quality of prescribing to elderly patients. The audit was designed to take a snapshot of the reasons for admission into the care of the elderly wards at the Vale of Leven Hospital. In particular to look at the effect of problems with medication as a contributory factor to an admission. Results show that, in line with other previously published work, a small but significant number of admissions (17%) were linked to problems with medication with 2 admissions (3.7%) where medication was the only reason for the admission. In addition the medical staff believed that 22% of these medication related admissions could have been avoided. Therefore a service aimed at identifying potential medication issues and improving compliance should have a positive impact on the local population

- (5e) Evaluation of physiotherapy therapeutic interventions within the Community older peoples team (COPT) using the Tinneti assessment tool. Indicated a 44% point shift in clients moving to a lower fall risk categories with improved gate, mobility and balance, reducing their risk of falling. 37.6% of the high risk group had moved to moderate risk and 8.7% to low risk The IQR data range indicates a significant shift ($p<0.05$) towards the lower end of the fall risk factor. This illustrates the effectiveness of the therapeutic interventions within the COPT

- (9pc) A 2nd.Cycle audit within the COPT team seeks to evaluate if there has been an improvement in the appropriate documentation of client centred, long term goals. Following 1st cycle audit, staff training was provided, new paperwork for staff developed along with a care pathway and client focused documentation. The second documentation audit was carried out between October and December 2011. Client interviews are currently being undertaken, supported by Margaret Black, patient involvement facilitator, CGSU. Initial analysis indicates that 94.5% of clients have either a long term

goal recorded or an exception code. This is a 54 percentage point improvement. The final report will be produced with recommendations for future practice.

- (10pc) A podiatry project: To ensure users of the service are well informed with both written and verbal information about the toe nail surgery procedure, aftercare and healing times reported that100% of respondents agreed the nails surgery procedure was fully explained to them before the surgery. Nearly 77% felt less pain than expected. 100% were given a leaflet on "looking after your toe" following the procedure. *"I thought the service was good even though I was extremely nervous". "I'm very satisfied with the service".*

- (4e) A Podiatry running in parallel with the above seeks to evaluate a 98% toe nail avulsion (removal) success rate at 12 months post operative review. And that 95% users of the podiatry nail surgery service are happy with end result of toe nail removal. Ensuring efficacy of the nail surgery procedure via the validated NHSGG&C Toe nail surgery protocol, including user satisfaction. At this project evaluates the outcome 12 months post, the results will be reported October 2012

- (6pc) A Health Visitors project evaluating the current parental hand book was designed to inform their decision to continue issuing the current handbook or to develop an alternative. The evaluation findings indicate the information contained within the handbook covers too wide an age range. There would be merit in producing separate handbooks for new parents and for families of older children. . Recommendations include further review, and re-printing of this resource by WD'S Parenting Review and Improvement Group.

- (2e) A Health Visitors project: Piloting a SHANARRI (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included) assessment tool in children & family teams GIRFEC. To implement a more appropriate method of assessing core families, in line with GIRFEC (Getting it right for every child) practice model, informing wider GG&C practice. This ongoing project commenced in September 2011 for 12 months and the PDNs are monitoring the impact of the assessment tool.

- (4s) District Nursing project to implement new guidelines in relation to COPD management of housebound patients with long term conditions. A pilot has been completed and is currently rolling out to all practices in the CHCP. This service has received 52 referrals since July 2011. Twelve assessments carried out & referred onto Prescribing, falls services, Physio. Dietetics & OT as appropriate. Report due 2nd quarter 2012.

- (8pc) District Nursing project aimed at reducing hospital / hospice admissions for end of life care, palliative care. The drivers for this project are "Living and Dying Well" and anticipatory prescribing within Long term conditions / Gold Standard. "Living and Dying Well uses the concepts of planning and delivery of care, and of communication and information sharing as a framework to support a person centred approach to delivering consistent palliative and end of life care in Scotland".

http://www.scotland.gov.uk/Publications/2008/10/01091608/0. This person centred, ongoing project commenced in May 2011, reporting in December 2012. Led by Val McIver, PDNs. Community Palliative Specialist Nurse. Currently, education sessions in progress for all care home staff to increase knowledge and skills in managing palliative care.

Effective Management of Vaccines in Primary Care. Yearly Report April 2011 – March 2012

In the period April 2011 to March 2012, 18 GP practices (100%) in West Dunbartonshire CHP undertook self audit. There are no outstanding audits. Follow-up (e.g. further submission of temperature records or repeat logging exercise) was required in 6 (33%) of the practices. 5 practices have completed follow up and 1 practice has follow up in progress. Domestic fridges are not suitable for use for vaccine storage and encouragingly all practices are using pharmaceutical fridges. During this period fifteen incidents were reported associated with potential cost of vaccine of £17,698.26. Eleven of these incidents could have been avoided if best practice was followed. If further support, advice or training on aspects of the cold chain is required please contact Karen Pawelczyk, Pharmacy Technician karen.pawelczyk@ggc.scot.nhs.uk 0141 201 4424 or Carol McCafferty, Project Administrator carol.mccafferty@ggc.scot.nhs.uk 0141 201 4464 for further details.

A new e learning module on vaccine storage and management is now available http://nhs.learnprouk.com/ It takes less than 30 minutes to complete and all relevant staff should be encouraged to undertake this training module to support best practice and prevent cold chain incidents.
Appendix 5: The annual summary report of Effective Management of Vaccines in Primary Care during April 2011 - March 2012.

Diabetic Retinal Screening

WDCHCP hosts the diabetic retinal screening service which provides the photographic retinal screening for people with diabetes in Greater Glasgow and Clyde,

Performance during 2011/2012

The screening uptake in 2011/12 increased by 1,375 (from 39,652 to 41,027) compared with 2010/11, but as the eligible screening population increased by 1,916, the percentage screened actually fell from 78.1% to 77.9%. The rate of referral to ophthalmology remained constant at 4.0%, slightly above the national rate of 3.5%

West Dunbartonshire CHCP interface with multi-partnerships projects

- Physiotherapy, MSK outcomes pilot audit: The pilot site findings have demonstrated the significant impact MSK physiotherapy has on patient’s pain, function and work status. The study has demonstrated that physiotherapy reduces pain and improves patient’s ability to carry out functional activities.

Physiotherapy enabled people to get back to work and stay in work. 10.8% were off work due to their complaint at the start of treatment and this reduced to 1.2% off work at discharge. 20.5% were struggling at work due to their complaint and this reduced to 3.6% on discharge**.** Over 63% of patients received 4 or fewer treatment sessions. The majority were able to reduce their pain relieving medication following physiotherapy which potentially represents significant cost savings. The most frequent health improvement discussion revolves around recommended physical activity levels but staff are starting to engage with the smoking cessation agenda and weight management. In April 2012 the Physiotherapy MSK service will be hosted within West Dunbartonshire and will introduce outcome measures to all MSK sites with 2012 and 2013, followed by a GG&C MSK audit.

- Podiatry Domiciliary Audit**:** The overall aim of the audit was to put in place a system to monitor and review a sample of new domiciliary patient records to ascertain use of the domiciliary screening tool, subsequent score and whether the patient was transferred to clinic if indicated. The audit has demonstrated that the performance target set by the KPI has been exceeded in relation to 80% of new domiciliary patient referrals received between 1st April 2010 and 31st March 2011 with a score of score ≤ 3 points being retained on domiciliary caseloads.
- Physical Health Survey in MHP. To Inform and prioritise future training for RMNs in physical health care. Report: Just over half of respondents had had some form of formal physical health training,
  however nearly everyone indicated that future training on physical health needs would be very useful when it came to carrying out their jobs as MH nurses. The top 5 areas requested for training were; 1. Assessment skills for physical health. 2.ECG; 3. Diabetes; 4,.Health Promotion;5. Nurse Prescribing.

- NHS GG&C : Audit of prevalence of pressure ulcers. This audit was commissioned to ascertain the numbers of patients on the District Nursing (DN) caseload who were at risk of developing pressure ulcers. Findings**:** Pressure ulcer prevalence was relatively low when individual components of Waterlow risk assessment tool were taken into consideration as well as patient dependency on others for activities in daily living. The prevalence study demonstrated the complexity of the DN caseload. Equipment should be used as an adjuvant to patient care and not as a replacement. Holistic patient assessment should be regularly carried out to highlight changes in the patient's condition which could result in development of pressure ulcers. Patients under social care who do not require nursing intervention may not be identified until treatment is required when pressure ulcers are identified. Brief summary of next steps: All patients should have Waterlow Scores carried out on admission to the DN caseload. A Waterlow Score of > 10 should also trigger the need for full mobility, continence, nutrition assessment. All pressure ulcers will be graded with the Scottish Adapted Pressure Ulcer Advisory Panel (EPUAP) grading tool. DATIX reports will be completed for all grade 3 and 4 pressure ulcers. Education on pressure ulcer prevention and maintenance of skin integrity will continue to be provided in primary care for clinicians involved in direct patient care

Appendix 2 - Complaints

NHS Complaints report

Year 2011: 1st January 2011 – 31st December 2011

WDCHCP Complaints & Learning

There were 14 formal NHS complaints received & concluded during 2011. Of these, we could not respond to the detail of one complaint because patient consent had not been received and of the 13 complaints responded to, 8 were considered to be fully or partially upheld. The learning has been extracted from these upheld complaints and would have been shared within / across services had this been appropriate. However it is clear from these that learning has been local and has not required any wider, system wide consideration. There have been no trends generally and given the relatively low incidence of formal complaint across services, it is difficult to identify any particular trend. Also, it is not unusual to see a higher incidence of complaint in mental health services given the nature of the service. It should be noted that there have been some instances where issues raised in this manner have been managed clinically and not through the formal complaints process.

In terms of response times, 12 of these 14 complaints received their response within 20 days, the other 2 being outwith the 20 days response target. This gives an overall 12 of 14 responses within target i.e. some 86% against the 70% target.

NHS Complaints received within the year 2011 – 1st January to 31st December 2011

Ref	Service	Subject	Outcome	Response	Learning
WD 11 01	Health and Community Care Services	Telephone services at CBHC	Partially upheld	< 20 days	Difficulties with the telephone system had been investigated and was in process of repair when the complaint arrived. At the time of complaint, the system was faulty. No clinical service learning.
WD 11 02	Children's Services	Assessment and treatment	Not upheld	> 20 days	Nil
WD 11 03	Mental Health Services	Staff attitude	Partially upheld	< 20 days	Staff reminded re expected approach in difficult circumstances and communication arrangements with this family were reviewed
WD 11 04	Mental Health Services	Treatment & appointment	Partially upheld	< 20 days	Issue was around communication re medication review. The importance of good communication was reinforced
WD 11 05	Mental Health Services	Treatment & support	Not upheld	< 20 days	Nil
WD 11 06	Mental Health Services	Treatment & support	Not upheld	< 20 days	Nil
WD 11 07	Children's Services	Immunisation	Fully upheld	< 20 days	Clinical record was inaccurate and has been corrected. Recording process was reviewed
WD 11 08	Health and Community Care Services – Podiatry	Treatment	Not upheld	> 20 days	Nil
WD 11 09	Mental Health	Clinical	Consent	< 20 days	Consent not received, could not respond to concern.

Ref	Service	Subject	Outcome	Response	Learning
	Services – LD	placement	not received		Linked to WD 11 12.
WD 11 11	Mental Health Services	Staff attitude	Partially upheld	< 20 days	Staff reminded re their expected approach in difficult circumstances
WD 11 12	Mental Health Services – LD	Clinical placement and hospital staff communication	Partially upheld	< 20 days	Issue around hospital staff communication with family upheld. Family request to be informed in similar circumstances noted in the patient record.
WD 11 13	DRS Services	Correspondence	Not upheld	< 20 days	Nil
WD 11 14	Mental Health Services	CPN visit arrangements	Partially upheld	< 20 days	The importance of good communication reinforced
WD 11 15	Mental Health Services	Correspondence	Fully upheld	< 20 days	Letter wrongly addressed thus breaching patient confidentiality. Importance of rechecking correspondence detail reinforced.

Appendix 3 Clinical Incident Report

West Dunbartonshire CHCP - Patient Clinical Incident Report 1 January to 31 December 2011

Over 2011 West Dunbartonshire reported 83 patient clinical incidents on Datix. The table below shows how this compares to other Divisions.

Incidents by Category and Division

	ADDICT	BOARD	EDCHP	ERCHCP	HOMELE	INVCHP	LEARN	MHP	NEGCHP	NWGCHP	RCHP	SGCHP	SLCHP	WDCHP	Total
Abscondment	2	0	0	0	0	13	4	436	246	3	30	37	0	1	772
Labs Blood/Product transfusion	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Challenging Behaviour	18	4	14	2	3	8	82	339	182	23	32	20	1	18	746
Clinical - Other	26	5	39	14	4	54	4	152	83	98	38	63	1	18	599
Communication	0	5	23	2	0	2	0	5	4	53	15	13	4	2	128
Consent	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Diet Inappropriate	0	0	0	0	0	0	0	1	5	1	0	0	0	0	7
Discharge or Transfer Problem	0	0	0	0	0	8	0	4	12	5	2	7	0	0	38
Gynaecology Incident	0	0	1	0	0	0	0	0	1	8	0	3	0	0	13
Radiation/Imaging Incident	0	0	16	0	0	0	0	0	1	1	0	0	0	0	18
Infection Control	0	0	1	0	0	1	0	1	2	2	0	1	0	0	8
Laboratory Medicine	0	0	0	2	0	0	0	2	0	60	3	3	0	2	72
Medical Devices & Equipment	0	2	12	1	0	3	0	1	5	9	6	7	0	6	52
Medication Incident	15	2	12	15	3	24	13	143	58	58	42	52	0	16	453
Patient Observations	0	0	0	0	0	0	0	1	2	0	3	0	0	0	6
Pressure Ulcer Care	0	0	0	0	0	2	0	0	7	5	9	10	1	1	35
Patient Records	3	4	59	1	0	1	0	5	39	50	6	3	0	7	178
Self Harm	12	0	7	2	1	4	29	442	354	20	19	39	0	3	932
Specimen Problem	0	0	0	1	0	1	0	0	4	23	1	1	0	0	31
Suicide	2	1	2	1	0	5	0	15	8	8	5	8	0	4	59
Treatment Problem	0	1	27	2	0	5	0	4	30	19	17	5	1	4	115
Totals:	78	24	213	43	11	131	132	1551	1044	446	228	272	8	83	4264

The highest category is Clinical Other. This category should only be used when no other more appropriate category is available. Analysis of the 'other' category should be made to identify any additional categories required and contact made to the Datix Manager to have these added to the system.

MHP refers to inpatient incidents, however since the last organisational restructure some areas may be reporting these through CHP/CHCPs e.g Dykebar Hospital now report these as RCHP.

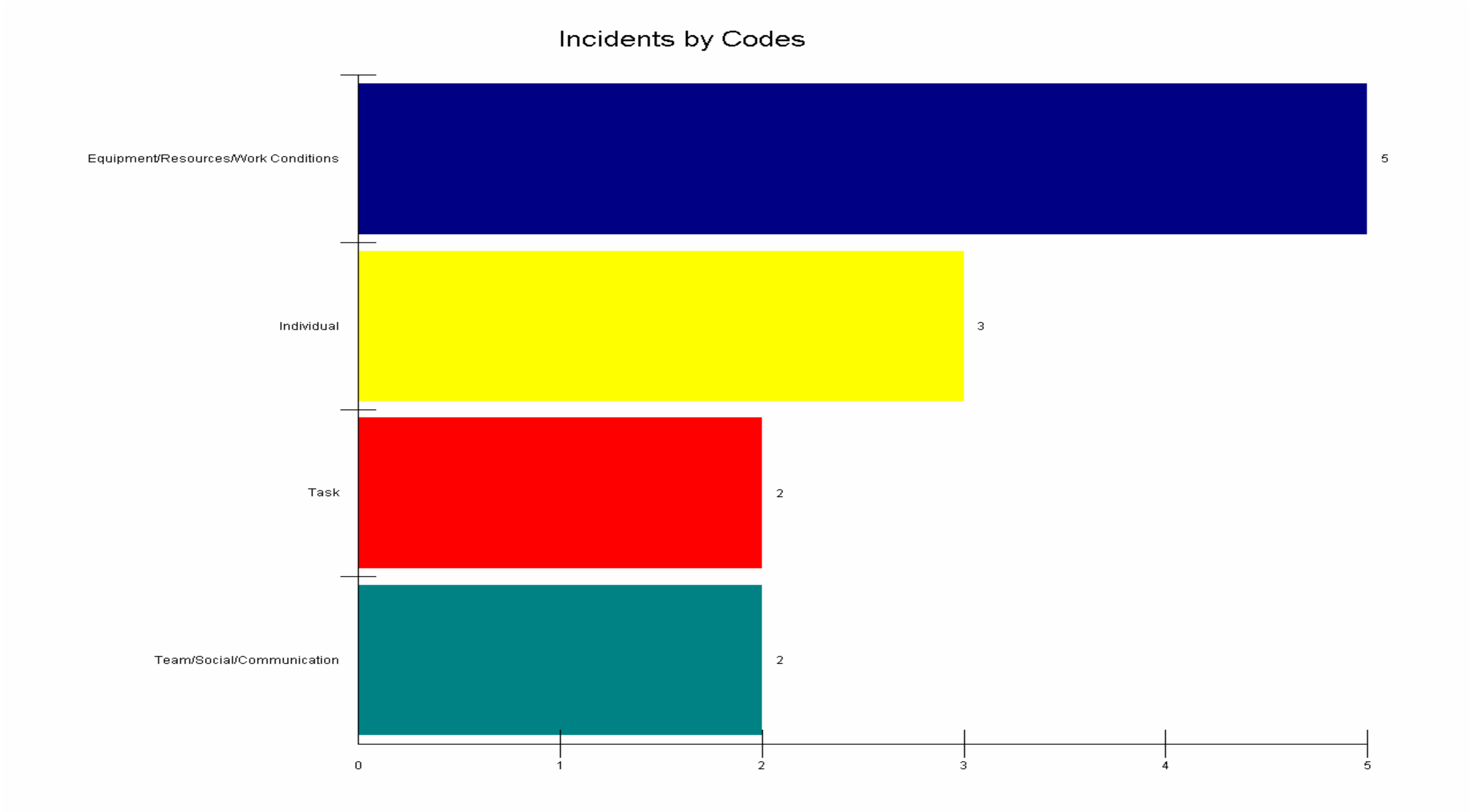
Significant Clinical Incident Review
West Dunbartonshire CHCP reported 2 Significant Clinical Incidents in 2011. Neither of the two has been closed on Datix and the review report is now overdue.

Local Incident Review
The table below shows the numbers of local reviews carried out in West Dunbartonshire by specialty.

Incidents by Specialty and Category

	BLOODL	CLIOTH	COMMUN	MEDDEV	MEDICA	RECORD	Total
Acute	0	0	0	0	1	0	1
Administration Services	0	0	0	0	0	1	1
Community Child Health	1	0	0	0	0	0	1
Older People's Mental Health	0	0	0	0	1	0	1
Health Visiting	0	1	0	0	2	0	3
Physiotherapy	0	1	1	0	0	0	2
Podiatry	0	0	0	1	0	0	1
Prescribing Team	0	0	0	0	2	0	2
Sexual Health	0	0	0	0	0	3	3
Totals:	1	2	1	1	6	4	15

The table below shows the main findings from local reviews.



The details behind these findings are:-

Incidents by Equipment/Resources/Work Conditions

Failure/Malfunction of Equipment Supplies	1
Poor Design/Functionality of Equipment	1
Workload	3
Staffing Levels	1
IT Network Issues	2
Totals:	8

Incidents by Individual

Inadequate Knowledge	1
New or Unfamiliar	2
Totals:	3

Incidents by Task

Task not Performed on Regular Basis	2
Task is Demanding (Physical or Mental)	2
Totals:	4

Incidents by Team/Social/Communication

Inadequate Handover	2
Records/Information not Available	1
Totals:	3