West Dunbartonshire Council

NHS Greater Glasgow and Clyde

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Health & Social Care Partnership

WEST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP

CLINICAL & CARE GOVERNANCE FORUM

12TH FEBRUARY 2016

Clinical and Care Governance is the process by which accountability for the quality of health and social care is monitored and assured, supporting staff in continuously improving the quality and safety of care and ensuring that wherever possible poor performance is identified and addressed.

Clinical and Care Governance within WDHSCP will be enacted with respect to five domains:

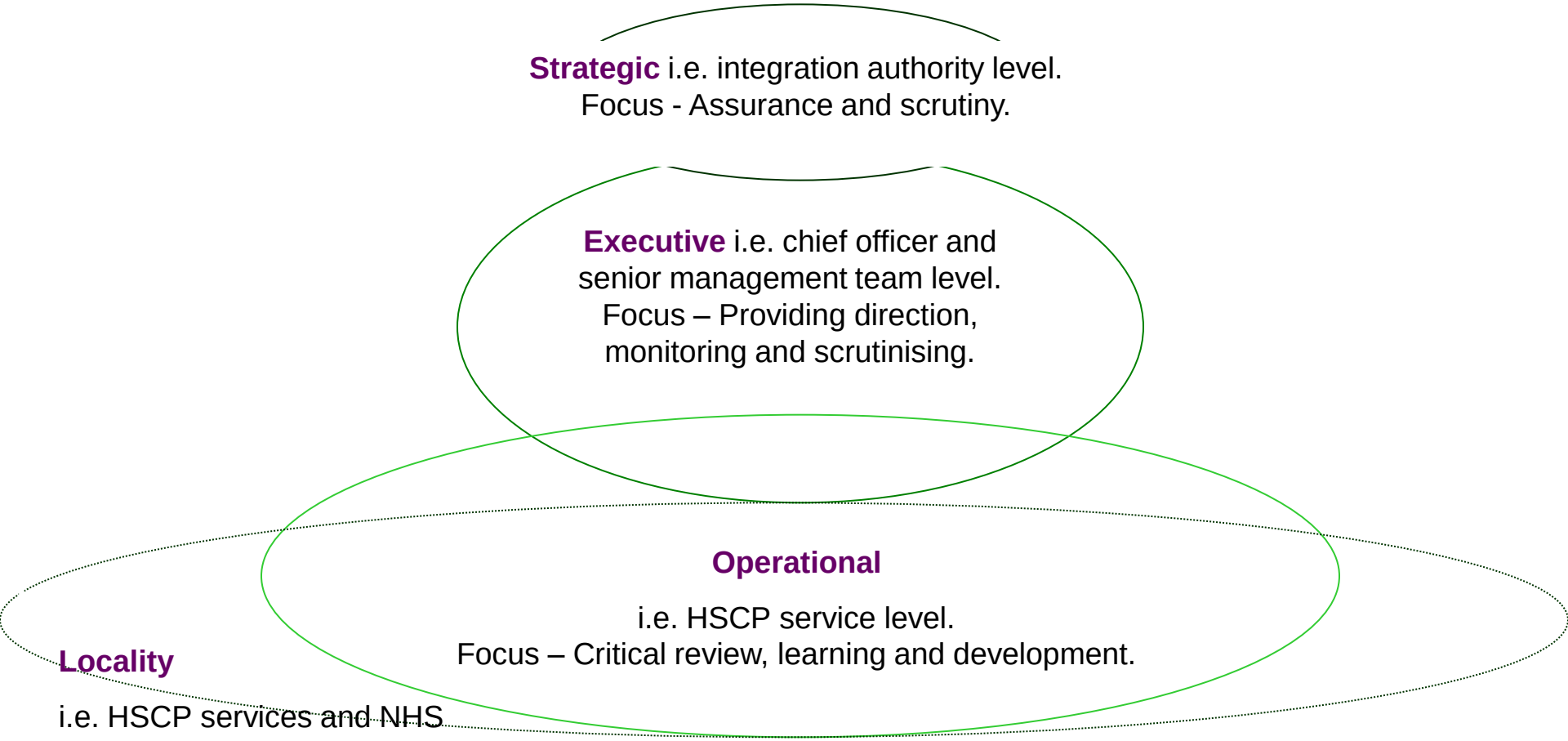
- **Quality Assessment** – encompassing performance review; information governance and inspection (including Care Inspectorate assessments of external providers).

- **Risk Management** – encompassing clinical incident, critical incident and significant case reviews and learning.

- **Service User Feedback** – encompassing complaints monitoring and learning.

- **Continuous Improvement** – encompassing all critical self-evaluation activities and learning, plus application of guidance.

- **Staff Governance** – encompassing staff governance framework, registration, revalidation and staff development.


Strategic i.e. integration authority level.
Focus - Assurance and scrutiny.
Executive i.e. chief officer and senior management team level.
Focus – Providing direction, monitoring and scrutinising.
Operational
i.e. HSCP service level.
Focus – Critical review, learning and development.
Locality
i.e. HSCP services and NHS external providers principally via locality groups.
Focus – Promoting critical review, learning and development.

Clinical and Care Governance is a product of structures and processes …

BUT how well it is able to benefit service users is highly dependent on the involvement of practitioners/operational staff on the “front line” and how relevant they feel it is to their everyday practice.

AND individual professionals should never forget that they are accountable for their individual clinical and care decisions.

So, an effective system of clinical and care governance should be one that stimulates multidisciplinary teams to engage in *reflective conversations* – in a consistent, systematic and on-going manner – that are focused on the detailed composition of care for specific conditions/pathways or patient/client groups .

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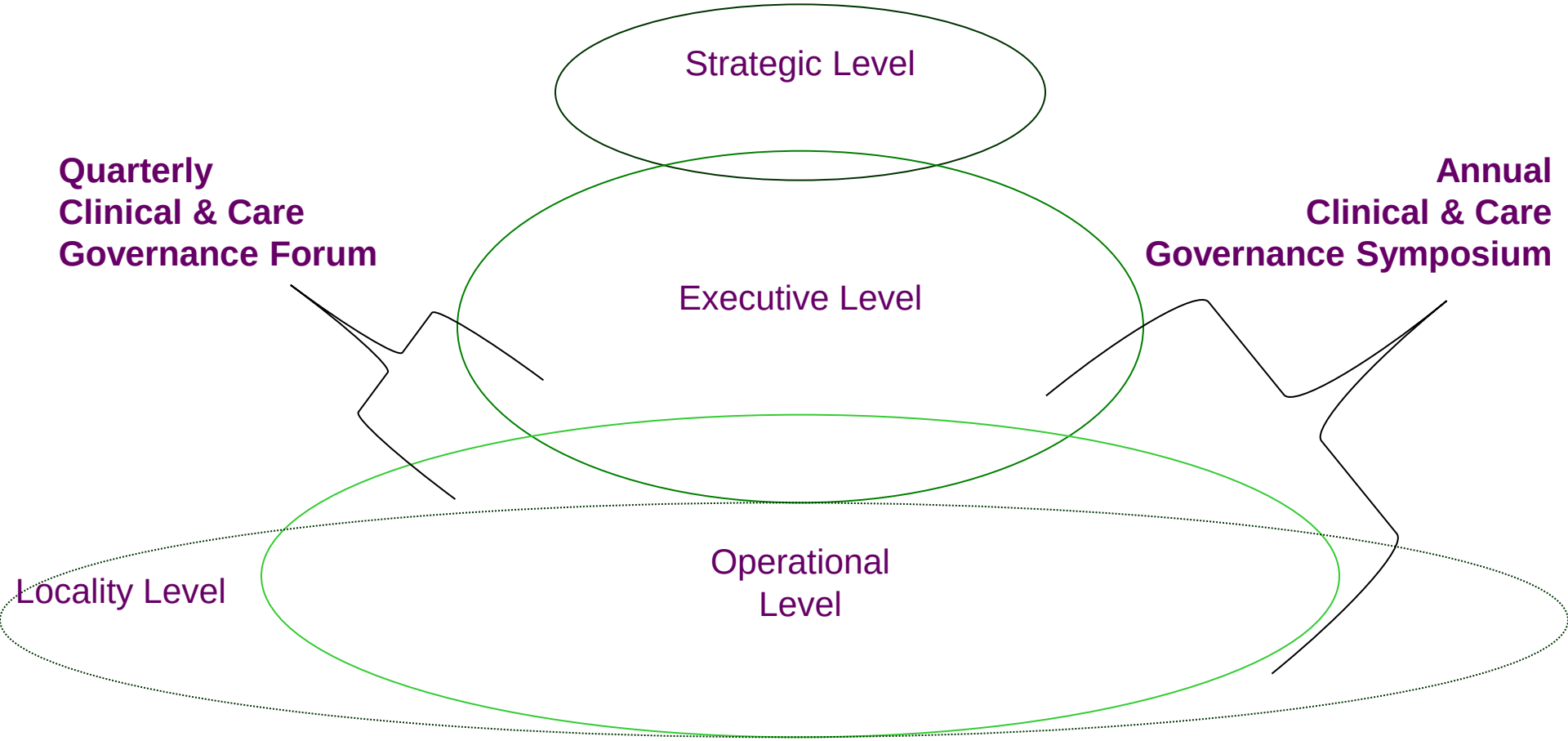
Fostering Wider Networking, Dialogue and Collective Learning

A local HSCP **Clinical and Care Governance Forum** will be maintained that brings together the members of the Clinical and Care Governance Group (representing the executive level) and all HSCP service managers/lead professionals (representing the operational level) on a quarterly basis.

Its purpose is to consider key quality issues; reflect on learning; and highlight good practice.

An annual HSCP **Clinical and Care Governance Symposium** will be organised that similarly focuses on key quality issue; and to which all HSCP staff, local NHS external contractors and other relevant stakeholders will be able to attend, participate in and sharing learning at.


Strategic Level
Quarterly
Clinical & Care
Governance Forum
Annual
Clinical & Care
Governance Symposium
Executive Level
Operational
Level
Locality Level

10.10 Developing Clinical and Care Governance “On The Ground”
Case Studies:

Pamela Macintyre, Lead Pharmacist

Kirsteen Maclennan, Acting Integrated Operations Manager for Adult Care & Hospital Discharge

Presentations with Q&A

11.00 Reflective Table Top Discussions

– What Can We Learn and What Examples Do We Have to Share?

11.20 Reflecting on Sector Leading Practice
Case Study:

The West Dunbartonshire Youth Mentoring Scheme

Carron O’Byrne, Manager – Looked After Children
Annie Ritchie, Fieldwork Manager – Children’s Services

Presentation with Q&A

12.00 Networking Lunch

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West Dunbartonshire HSCP
Extended Management Team Session

CLINICAL & CARE GOVERNANCE

Pamela Macintyre
Prescribing Lead
February 2016

Prescribing Support Team – who we are and what we do

The Team

3.6 WTE pharmacists and 3.8 WTE pharmacy technicians

What we do

Promote the safe, effective and economic use of medicines across West Dunbartonshire. Provision of the Care at Home Pharmacy Service (CAPS)

Our Service Users

GPs, Practice Nurses, District Nurses, Care at Home Staff, Learning Disabilities Staff, Care at Home recipients (carers and families) and patients

Quality Assessment

Process	Accountability
Peer review of Medication Reviews	HSCP Prescribing Team/ PPSU
Peer review of clinical activities (HF and Pain)	Senior Clinical Pharmacists with Specialist knowledge
Current/Reviewed Service Plan	Head of Service
CAPS service updates	Integration Fund Group
CAPS waiting times	Head of Service/Integration Fund
Falls Reviews – waiting times	HSCP Prescribing Team

Risk Management

Overview of Prescribing Budget; balance of costs vs efficacy
HSCP Medication Policy; integration across health and social care
Significant Event Analysis and learning
DATIX entries
Shared learning from other teams

Service User Feedback

GPs comment at annual prescribing visits/ locality meetings
Evaluation from training sessions provided
CAPS/Care Homes; current GAP, no informal/formal process in place currently

Continuous Improvement

NOAC audit against guidelines

Review of training activity

Mobile technology

Staff Governance

Monthly GPhC registration check
KSF
PDP
Regular one-to-one meetings
Regular Team Meetings

PDSA (Plan, do, study, act) Example Speed of CareFirst Write-Ups (CAPS)

Cycle 1 – Oct 13 – Feb 14

PLAN

Issue identified with delay in information going onto Care First, especially around weekends due to staff work patterns

Standard - 90% of visits written up on same day or next day (Day 1)

DO

60 visits were randomly selected in each time period and the time taken for the visit information to be recorded on Care First was measured

STUDY

Results

Same Day	Day 1	Day 2	Day 3	> Day 3	No entry
52%	23%	10%	10%	3%	2%

Only 75% achieved the audit criteria

Issues identified

Prescribing Team waiting until next on the service before writing up
process for booking resulted in many late afternoon visits which were not entered until at least the following day

ACT

Staff rota changed
Access to Care First obtained at other sites (DHC, CBHC and Hardgate)
Bookings were routinely made the day before visit which allowed for better use of time and for return to base/other site for Care First write-up on same day

PDSA Repeated

2 further occasions
Cycle 2 - Mar 14 – Jun 14
Cycle 3 - Apr 15 – Oct 15

Cycle	Same Day	Next Day (Day 1)	Day 3	Day 4	> Day 4	No entry
1	52%	23%	10%	10%	3%	2%
2	62%	28%	3%	0%	7%	0%
3	98%	2%	0%	0%	0%	0%

Cycles 2 & 3 both achieved audit standard
Will be re-measured after introduction of paperless system

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Clinical & Care Governance: Community Hospital Discharge Team

Kirsteen Maclennan
Acting Integrated Operations Manager

The Community Hospital Discharge Team:

- identifies individuals early who may require assessment or support to facilitate safe and timely discharge from hospital
- Provides an integrated approach to care which optimises independence for the individual and maximises opportunities for recovery at home
- Identifies the requirement for ongoing support and ensures timely transfer to appropriate services, according to primary care need

The team comprises:

Clinical Rehab: 2 Nurses, 2 Physios, 3 OTs, 2 Rehab Assistants

Community OT: 2 OTAs

Social Work: 8 Social Workers, 3 Social Work Assistants, 1 Hospital Discharge Coordinator

Quality Assessment

- Team Leads authorise each Single Shared Assessment
- Regular Case File Audits & feedback via supervision
- Daily performance review of waiting times (FFD Home)
- Daily performance review of delayed discharges (Edison)
- Analysis of month on month trends (NHSGGC performance data)
- Liaison with Quality Assurance Team regarding external providers & representation by Placement Review Officer at Care Home Providers Meetings
- Liaison with Care Inspectorate, as required, to agree appropriate placements

Risk Management

- Risk Register for Service (CHDT, COPT, ACT)
- Datix reporting
- Joint Seniors & Team Leads Meetings across service to promote exchange of information & shared learning
- Developing mechanism for regular multi-disciplinary case analysis/ significant event analysis (1 case per quarter)

Service User Feedback

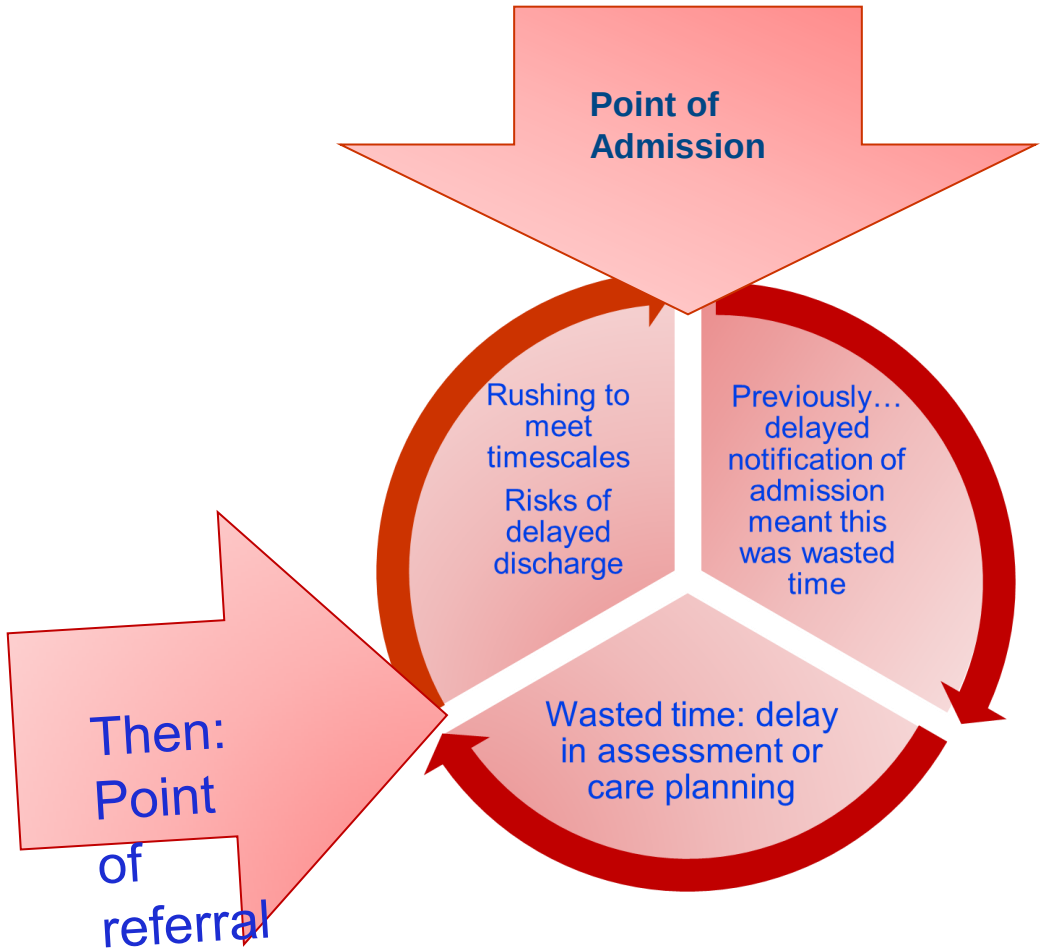
- Goal/ Outcome based measures for all inputs from CHDT
- % study of admissions to care homes to ensure appropriate outcome for service user
- Developing mechanism for reflection following enquiries/ complaints – to support staff confidence & develop practice

Staff Governance

- Maintenance of log of registration/ revalidation for relevant professions
- PDPs/ KSFs – baseline training (ASP, CP)
- Regular Supervision (4-6 weekly) timetabled for year
- Monthly team meetings timetabled for year
- Professional Forums (Nursing, OT, Social Work)

Continuous Improvement

- Establishment of Hospital Discharge Forum – linking in with & sharing practice with peers from other authorities
- Case File Audits (all disciplines) and highlighting common themes for development
- Development of agile working & better access to shared systems, particularly in interface with acute settings (i.e. clinical portal)
- Developing mechanism for regular multi-disciplinary case analysis (1 case per quarter)
- Care Inspectorate, Mental Welfare Commission reports


Point of Admission
Rushing to meet timescales
Risks of delayed discharge
Previously… delayed notification of admission meant this was wasted time
Wasted time: delay in assessment or care planning
Then: Point of referral

- Bench marked performance with other authorities; visited other teams; service re-design
- Streamed roles within team:
  - Hospital Discharge Liaison Workers (including practical support)
  - Complex Discharge Assessors
  - Home Discharge Assessors
  - Care Home Placement Review Officer
  - Clinical Rehab
- Allows for concentrated efforts and small caseloads, resulting in timely discharge becoming more achievable

- Hospital Discharge Liaison Workers aim to;

- be present on wards – promoting a culture of early referrals and discharge planning in hospital
- promote awareness with Consultants and ward staff to submit referrals as close to the point of admission as appropriate
- assess a person's needs at the earliest opportunity, including identifying people who cannot return home
- identify people who are deemed to lack capacity and initiate AWI processes

- With this information the wider Hospital Discharge Team can then;

- involve patients and carers sooner in discharge planning
- develop and deliver integrated care and support packages in conjunction with other HSCP services
- ensure that people receive the most appropriate care and opportunities at the point of discharge
- monitor and review care package for four weeks post discharge, ensuring seamless transition to other services if required

As at 30th September 2015:

- **465 early assessments had been undertaken**

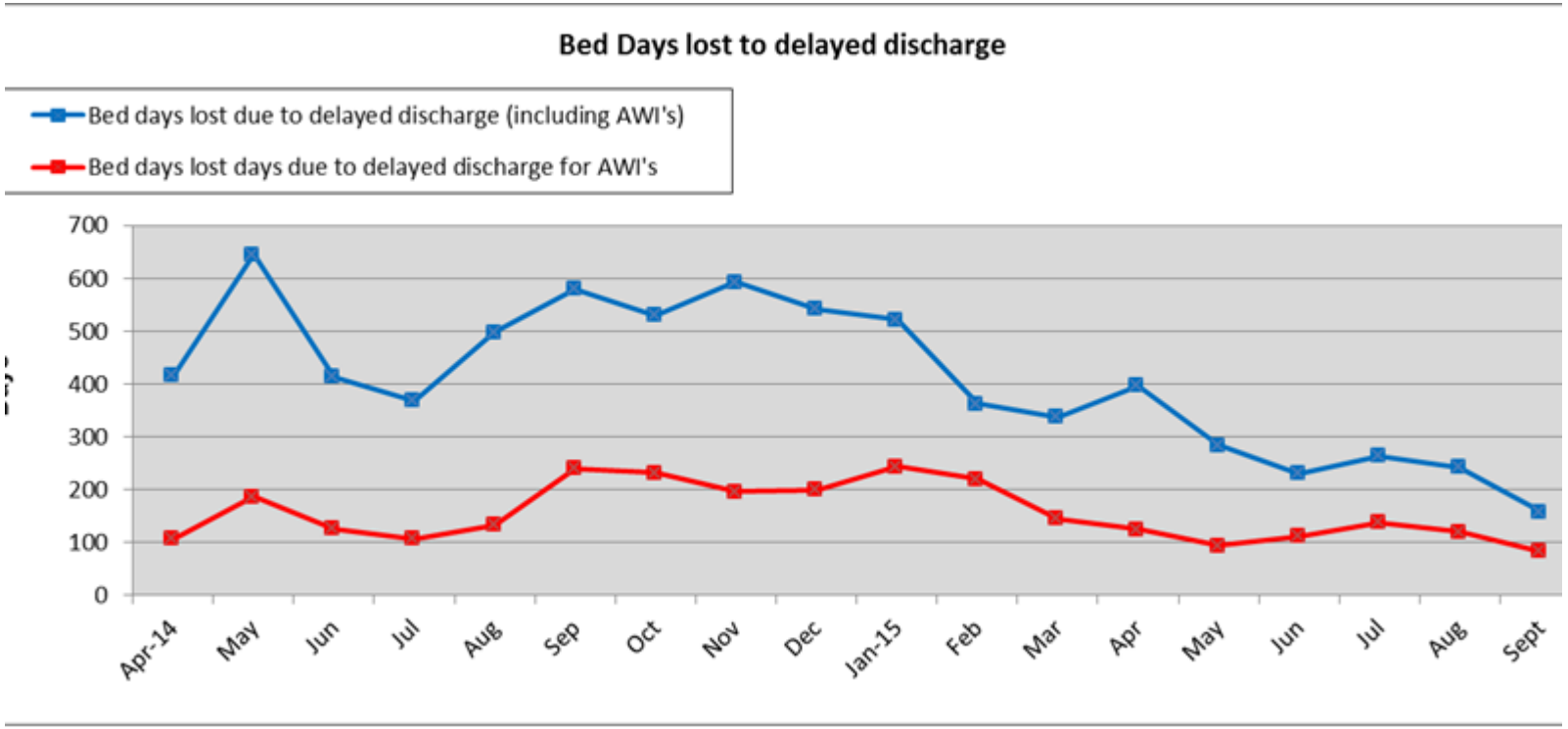
- **194 individuals were discharged following advice/ guidance/ practical support**

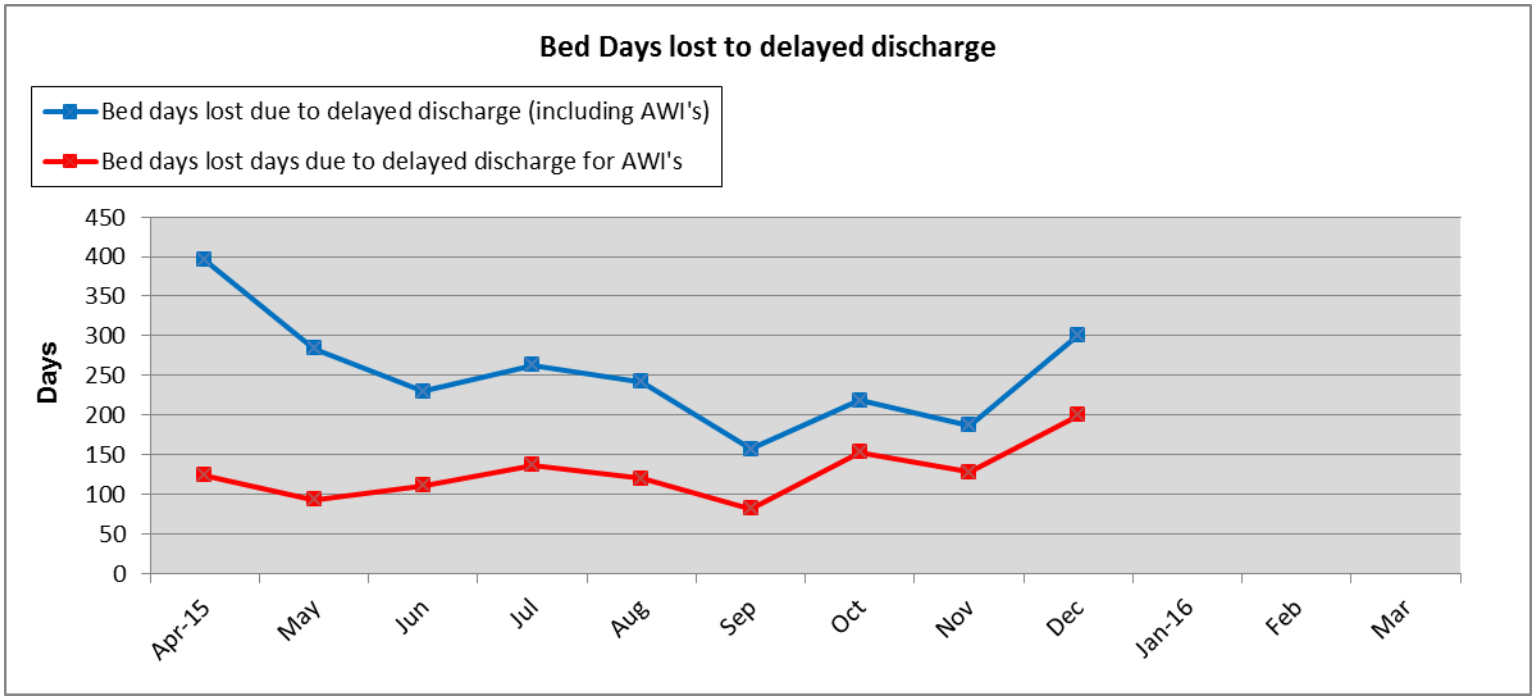
- **163 individuals were discharged home with support**

- **87 individuals were allocated to complex assessors**

- **0 individuals required on going practical support**

- **21 inpatients were receiving on-going monitoring from Early Assessors**


Bed Days lost to delayed discharge
Bed days lost due to delayed discharge (including AWI's)
Bed days lost days due to delayed discharge for AWI's
700
600
500
400
300
200
100
0
Apr-14
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan-15
Feb
Mar
Apr
May
Jun
Jul
Aug
Sept


Bed Days lost to delayed discharge
Bed days lost due to delayed discharge (including AWI's)
Bed days lost days due to delayed discharge for AWI's
Days
450
400
350
300
250
200
150
100
50
0
Apr-15
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan-16
Feb
Mar

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Young People & Care Experienced Mentoring Project

Welcome

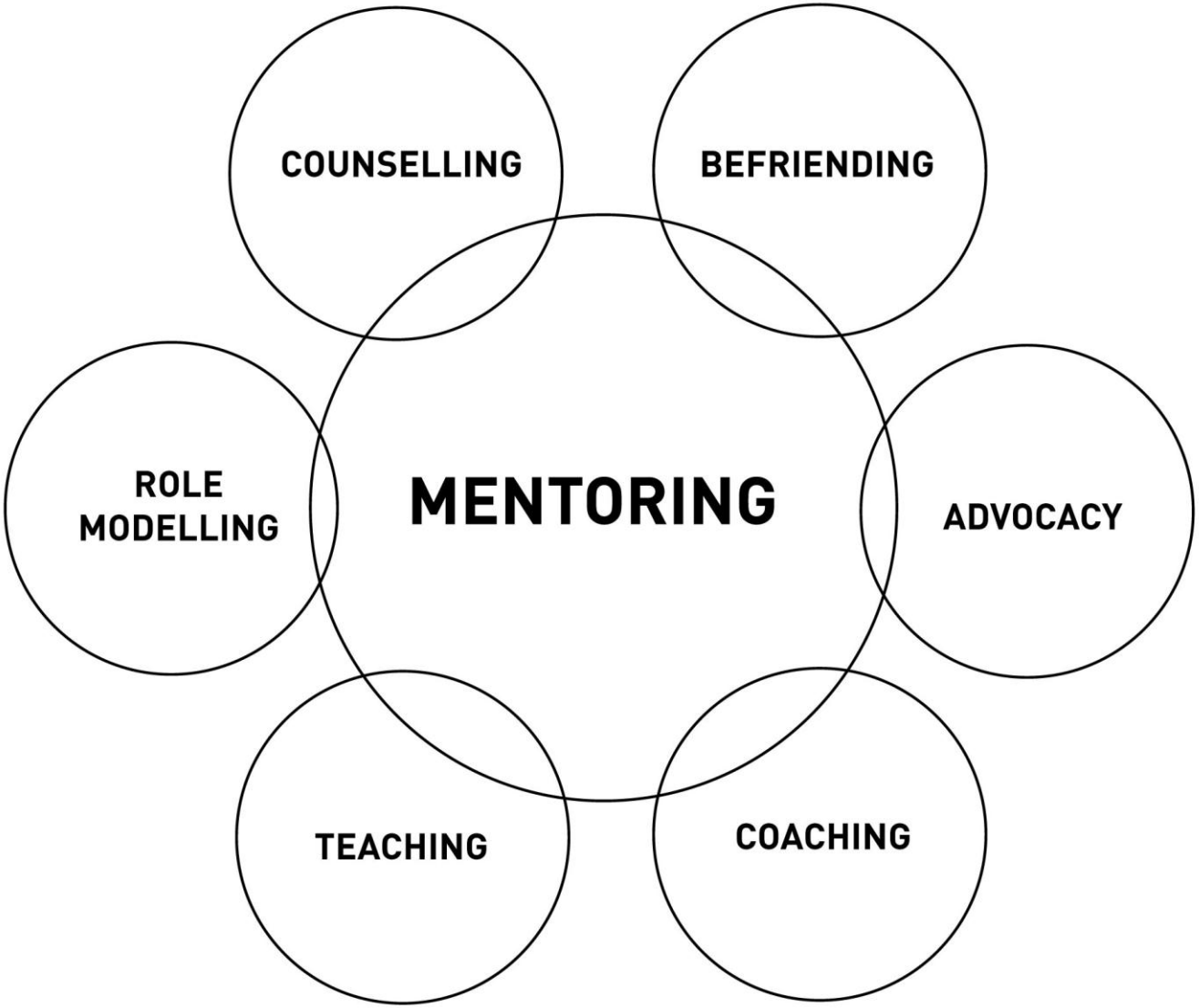
Annie Ritchie
Children Services Field Work Manager

Carron O’Byrne
Manager Looked After Children

What is Mentoring and Befriending?

Mentoring

A close relationship between two people in which the Mentor will actively support, guide and assist the Mentee towards making positive changes in his or her life by working towards realistic achievable goals or targets.


COUNSELLING
BEFRIENDING
ROLE MODELLING
MENTORING
ADVOCACY
TEACHING
COACHING

Befriending

The role of the Befriender is to provide informal social support, with the primary objective of forming a trusting relationship, usually in order to reduce isolation and to provide a relationship where none currently exists.

Project History

- Project started in 2003
- Initially a Youth Justice based Project, working with Young People involved in or at risk of offending
- Full time Coordinator appointed in March 2004
- Due to the success of the initial client group the criteria was expanded to incorporate Looked After and Accommodated Young People in 2004
- Use of Volunteers and sessional staff streamlined in 2007.
- 2007 the project standardized and evaluated a mandatory training program for Mentoring and Befriending.
- In 2012 the project the referral remit widened to incorporate any young person with an identified need.

Project Make-Up

- Team Leader Youth Services providing leadership and scrutiny for the project
- SSW with Lead for Mentoring
- Mentoring Coordinator
- Assistant Coordinator
- Admin Support
- 33 Mentors

The Aims of the Project

- **To act as a gateway to opportunities for young people**
- **To provide support, advice, guidance and direction.**
- **To provide a positive, non judgmental relationship build on mutual trust.**
- **To ensure consistent regular contact with the young person.**
- **To provide positive role modeling for young people.**
- **To enable young people to achieve realistic and achievable outcomes.**
- **To reduce the young persons risk taking behaviors.**
- **To support access to positive activities and space to talk.**
- **To advocate for and work in partnership with the young person.**
- **To ensure the young persons confidentiality, only breaking this if the young person or another is at risk.**
- **Ensure high quality of service delivery through various methods including regular supervision of both mentors and mentoring coordinators.**

Identified Outcomes

Young People

- Improved Confidence
- Eating for Well-being
- Improved Life Skills
- Increased Creativity
- Getting and Staying Fit, Active and Healthy
- Increasing Resilience
- Increasing Social Networks
- Becoming Employment and Training Ready

Who Are Our Mentors

- Local people who are willing to commit to and interested in supporting and helping young people
- Volunteer and Sessional workers, recruited from the wider community
- All ages from both males and females
- All mentors have undertaken training, have an awareness of issues facing young people and are part of the PVG scheme.
- Mentors have a variety of life skills and experience are level headed and able to engage young people.
- Are committed, reliable and caring.

National and Local Recognition of Best Practice

- 2014 Winner of National Care Accolade for Preventing Offending and Reducing Re-offending Award
- 2014 Winner of The Social Care and Justice Project of the Year
- 2014 Winner of The Directors Commendation
- 2015 Joint Winners of The Social Care and Justice Project of the Year
- The project has been involved in and mentioned in Scottish Government research into mentoring for Looked After Young People and Care Leavers.
- Two MSPs visited the project and tabled a motion in Parliament to recognize the good work of the project.
- The model used in West Dunbartonshire has been adopted by the Life Changes Trust and the Scottish Mentoring Network as best practice and is now the recognised as the national mentoring model.

Indicators of Success for Our Young People

- Increasing volume of referrals
- Provided support to over 240 young people
- High Numbers of Young People who evaluated the service as excellent.
- Decreased rate of recidivism
- Length of relationship, frequency of contact
- Improved outcomes for young people
- On-Going Achievements for young people
- Young People involved in a successful National photography project 3 years running.
- One young person has recorded her own CD in a local studio.
- Several young people have produced photo books which supported them onto other exciting opportunities.

What the Young People told us about Mentoring ?

- *I didn't want it to end*
- *It feels like someone cares*
- *I feel more confident*
- *It helped me get prepared for college*
- *I really liked mentoring it helped keep me on the straight and narrow*
- *It lets me talk about anything that is on my mind*
- *It made me realise I was wasting time*
- *J is brilliant I can talk openly to her*

Next Steps

Supporting the development of Mentoring in the 3rd Sector for care experienced young people.