MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE

COMMITTEE FRIDAY 2 FEBRUARY 2018,

9:30AM – 12 NOON ROOM 1, SPYNIE DENTAL

CENTRE, ELGIN

NOTICE IS HEREBY GIVEN that a Meeting of the **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE** is to be held in **Room 1, Spynie Dental Centre, Elgin** on **2 February 2018** at **9:30am** to consider the business noted below.

Pam Gowans
Chief Officer

26 January 2018

AGENDA

1. Welcome and Apologies
2. Declaration of Member's Interests
3. Minute of the Meeting of the Integration Joint Board Clinical and Care Governance Committee (IJB CCG) dated 3 November 2017
4. Action Log of the IJB CCG Committee dated 3 November 2017
5. Update to Clinical and Care Governance Framework – Report by the Chief Officer
6. Proposed Change to Meeting Dates 2018/2019 – Report by the Chief Officer
7. Annual Assurance Report to NHS Grampian Clinical Governance Committee – Report by the Chief Officer

8. Updated Clinical and Care Governance Operational Arrangements – Report by the Head of Adult Services and Social Care and the Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services

9. Duty of Candour – Report by the Chief Officer

Quarterly Summary Reports on External Reports, Audits and Reviews for Moray

10. Clinical Audit – Re-Audit of Elgin Young Person's Diabetes Clinic user Experience: December 2016 – February 2017 – Report by the Chief Officer

11. Clinical Audit – Physiotherapy Telephone Assessment User and Staff Experience Audit: Westhill and Peterhead Departments: May – July 2016 – Report by the Chief Officer

12. Clinical Audit – Audit of Record Keeping – School Nursing 2015/16 – Report by the Chief Officer

13. Clinical Audit – Audit of Children and Young People Community Nursing Record Keeping in NHS Grampian Health Visitors 2015/16 – Report by the Chief Officer

Self-Assessment Reports

14. Primary Care Contracts Team – Report by the Chief Officer

15. Community Pharmacy – Report by the Chief Officer

MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

MEMBERSHIP

VOTING MEMBERS

Professor Amanda Croft (Chair)	Executive Board Member, NHS Grampian
Councillor Shona Morrison (Vice Chair)	Moray Council

NON-VOTING MEMBERS

Ms Tracey Abdy	Chief Financial Officer
Mr Ivan Augustus	Carer Representative
Mr Tony Donaghey	UNISON, Moray Council
Ms Pamela Gowans	Chief Officer, Moray Integration Joint Board
Mrs Linda Harper	Lead Nurse, Moray Integration Joint Board
Dr Ann Hodges	Moray Integration Joint Board Secondary Care Advisor
Mrs Susan Maclaren	Chief Social Work Officer, Moray Council
Dr Graham Taylor	Registered Medical Practitioner, Primary Medical Services
Mrs Val Thatcher	Public Partnership Forum Representative

ADVISORS

Mr Sean Coady	Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services, Health and Social Care Moray
Ms Jane Mackie	Head of Adult Health and Social Care, Health and Social Care Moray
Mrs Liz Tait	Professional Lead for Clinical Governance and Interim Head of Quality Governance and Risk Unit

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

FRIDAY 3 NOVEMBER 2017

ROOM 1, SPYNIE DENTAL CENTRE, ELGIN

PRESENT

VOTING MEMBERS

Professor Amanda Croft (Chair)	Executive Board Member, NHS Grampian
Councillor Shona Morrison (Vice Chair)	Moray Council

NON-VOTING MEMBERS

Ms Pam Gowans	Chief Officer, Moray Integration Joint Board
Dr Ann Hodges	Registered Medical Practitioner, Non Primary Medical Services
Mrs Val Thatcher	PPF Representative

IN ATTENDANCE

Mr Sean Coady	Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services, Health and Social Care Moray
Ms Jane Mackie	Head of Adult Health and Social Care, Health and Social Care Moray
Ms Debbie Barron	Clinical Quality Facilitator
Mr Angus Henderson	Dental Lead, Health and Social Care Moray
Mrs Caroline Howie	Committee Services Officer, as Clerk to the Committee

APOLOGIES

Mr Ivan Augustus	Carer Representative
Mrs Linda Harper	Lead Nurse, Moray Integration Joint Board
Mrs Susan Maclaren	Chief Social Work Officer, Moray Council
Dr Graham Taylor	Registered Medical Practitioner, Primary Medical Services
Mrs Liz Tait	Professional Lead for Clinical Governance and Interim Head of Quality Governance and Risk Unit

1.	**ORDER OF BUSINESS**
	The Meeting agreed to vary the order of business as set down on the Agenda and take Item 9 “Public Dental Services” as the first item of business to allow Mr Henderson, who was presenting the report, to leave the meeting at the earliest opportunity.
2.	**PUBLIC DENTAL SERVICES**
	A report by the Dental Services Manager, Moray Public Dental Services, informed the Committee of a review of Clinical and Care Governance arrangements in Primary Care in respect of Public Dental Services. The relocation of Public Dental Services from Laich Dental Practice in Lossiemouth had been carried out successfully. Long term absences are impacting on the waiting list for Relative Analgesia (RA) sedation, known as gas and air by patients, this is being counteracted by providing sessions in RA sedation to enable other clinicians to carry this out and reduce waiting times. Mr Henderson advised he is due to leave the service at the end of the year and there was a risk to the service if recruitment to the post failed. Following discussion the Committee agreed to note the report. Mr Henderson left the meeting at this juncture.
3.	**DECLARATION OF MEMBER’S INTERESTS**
	There were no declarations of Member’s interests in respect of any item on the agenda.
4.	**MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE DATED 4 AUGUST 2017**
	The minute of the meeting of the Moray Integration Joint Board Clinical and Care Governance Committee dated 4 August 2017 was submitted and approved.
5.	**ACTION LOG DATED 4 AUGUST 2017**
	The Action Log of the Moray Integration Joint Board Clinical and Care Governance Committee dated 4 August 2017 was discussed and the following points were noted: Under reference to item 3 of the log “Action Log Dated 5 May 2017”; the requested report on National Care Standards was not on the agenda. The Chief Officer advised the National Care Standards were now in place and an update would be provided at a future meeting. Under reference to item 3 of the log “Action Log Dated 5 May 2017”; the Committee agreed this item should be removed from the log as it was felt a report was not required as staffing issues are continually monitored. All other items were on schedule as per the Action Log.

6.	**CLINICAL AND CARE GOVERNANCE OPERATIONAL ARRANGEMENTS**
	A report by the Head of Adult Services and Social Care, and the Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services provided an update to inform on actions that have taken place regarding operational clinical governance arrangements; specifically focusing on the level of reporting arrangements operationally in conjunction with other policies. During discussion it was noted there was no information on Mental Health within the report and Committee agreed this should be included; the Head of Adult Health and Social Care was tasked with ensuring this is reported to the next meeting. Following further discussion on the operational arrangements the Committee agreed to: i) note the basic structure of operational clinical governance arrangements will be retained; ii) note an Adverse Events Review Group will be established, as a subgroup of Senior Management Team meetings and convened by Heads of Service on a quarterly basis. The group will also incorporate the review of complaints, ombudsman reviews and the quality of reviews; iii) note the reporting arrangements will be improved to reflect more evidence based actions, using the NHS Grampian Clinical Governance Sector Reporting Framework template; iv) note the role of the Clinical Governance Support unit will continue to be essential as a central function in supporting clinical quality improvement and governance; v) note clinical quality indicators will be developed as part of the overall performance framework to enhance assurance; and vi) task the Head of Adult Health and Social Care with ensuring information on Mental Health is incorporated into the report for the next meeting.
7.	**CLINICAL AND CARE GOVERNANCE FRAMEWORK**
	A report by the Head of Adult Services and Social Care, and the Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services presented Committee with an update of the Clinical and Care Governance Framework. The Chair raised concern that there was only 1 clinician in attendance and stated she would like information included in respect of the meeting Quorum. It was stated that agenda setting meetings would be held three weeks prior to Committee and information was to be added to the Framework in this respect. During further discussion clarification was sought on timescales for reporting to the Board. It was agreed that as minutes of the Clinical and Care Governance Committee are reported quarterly to the Board that an annual report to advise on Committee work should be presented to the Board with interim reports being issued as required for specific items. As no one was otherwise minded it was agreed to task the Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services with updating the Framework in respect of the above.

	Thereafter the Committee agreed to: i) note the Clinical and Care Governance Framework attached as Appendix 1 of the report; ii) note the intention to review the Framework annually; and iii) task the Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services with updating and issuing the Framework as discussed.
8.	**ADVERSE EVENTS AND COMPLAINTS REPORTING**
	Under reference to paragraph 8 of the minute of the meeting dated 4 August 2017 a report by the Head of Adult Services and Social Care, and the Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services provided a quarterly complaints report. It was noted the number of adverse events in quarter 2 had fallen significantly since quarter 1, due to a reduction in adverse events within Learning Disabilities. Following discussion the Committee agreed to note the Quarter 2 (July – September 2017) Health and Social Care complaints and adverse events summary.
9.	**ESCALATION PROCESS**
	The Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services opened the discussion and sought clarification on how Committee envisaged the process of escalation of items functioning and how it can challenge itself. During discussion it was agreed there had been a gradual evolution of processes thus far, reports were clear and easier to read than when Committee first met and the current approach was felt to meet the needs of the Committee. It was further agreed that any items on the agenda that required to be brought to the attention of the Board would be agreed during discussion of the item. Following further discussion the Committee agreed items of significance would be reported to the Board as required.

MEETING OF MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

FRIDAY 3 NOVEMBER 2017

ROOM 1, SPYNIE DENTAL CENTRE, ELGIN

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Action Log dated 4 August 2017	National Care Standards report report to be presented in April setting out the partnership position.	April 2018	Pam Gowans
2.	Clinical and Care Governance Operational Arrangements	Incorporate information on Mental Health within noting report to next meeting.	Feb 2018	Jane Mackie
3.	Clinical and Care Governance Framework	Investigate possible issue of only 1 clinician attending Committee. Update and issue Framework as discussed at meeting.	Feb 2018 Feb 2018	Pam Gowans Sean Coady

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 2 FEBRUARY 2018**

SUBJECT : **UPDATE TO CLINICAL AND CARE GOVERNANCE FRAMEWORK**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 The purpose of this report is to present the Moray Integration Joint Board (MIJB) Scheme of Administration, a section of which supersedes the Clinical and Care Governance Framework, for consideration.

2. RECOMMENDATION

2.1 It is recommended that the Moray Integration Joint Board (MIJB) Clinical and Care Governance Committee:

i) consider and note the Scheme of Administration (agreed by the MIJB on 31 August 2017), as attached at APPENDIX 1;

ii) consider any changes required to the Clinical and Care Governance Committee provisions as set out in Section B of the Scheme of Administration; and

iii) task the Chief Officer with taking a report with any recommendations to the MIJB at its meeting in March 2018.

3. BACKGROUND

3.1 The MIJB agreed at its meeting on 31 August 2017 (Para 7 of the Minute refers) updated Standing Orders for the MIJB and its Committees. A Scheme of Administration was deemed to form part of these Standing Orders, which is now attached at **APPENDIX 1**.

3.2 A new provision within the updated Standing Orders was an agreed change that MIJB committees would form part of the standing orders. Section 14.2 of the updated Standing Orders states ‘‘The Membership, Chairperson, remit,

powers and quorum of any Committee or Working Groups will be determined by the Board and once agreed, set out within a Scheme of Administration and periodically reviewed".

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 A revised Clinical and Care Governance Framework was presented to the Clinical and Care Governance Committee on 3 November 2017 (Para 7 of the Minute refers). It was requested at this meeting to amend the framework to include quorum protocol for the future business of the Committee. As highlighted above, this document is now superseded with the Scheme of Administration, inviting members to consider quorum in which business will be conducted and other changes they would wish to consider for recommendation to the MIJB.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019.

As set out within MIJB's updated Standing Orders agreed at its meeting on 31 August 2017.

(b) Policy and Legal

There are significant policies, standards and guidelines that govern the business of health and social care to ensure high quality, safe and effective service delivery. The governance arrangements require to be robust and reliable. The Board need to be assured that the framework is fit for purpose.

(c) Financial implications

Litigation and implications resulting from malpractice and any harm done to people in our care carries a high risk financially.

(d) Risk implications

Arrangements set out within Section B of the Scheme of Administration should set out a robust process to mitigate harm and any existing risks should be carried and managed within the operational risk register of Health and Social Care Moray.

(e) Staffing implications

Good governance arrangements made clear to all involved in the delivery of health and social care are critical to ensure a safe, effective and confident workforce.

(f) Property

None associated with this report.

(g) Equalities

None associated with this report.

(h) Consultations

Consultations have been undertaken with the following staff who are in agreement with the content of this report where it relates to their area of responsibility:

- Legal Services Manager (Licensing & Litigation)
- Caroline Howie, Committee Services Officer
- Chief Financial Officer, MIJB
- Chief Officer, MIJB

6. CONCLUSION

6.1 Any requested revision(s) to the attached Scheme of Administration will be recommended to the MIJB at its meeting in March 2018.

Author of Report: Catherine Quinn, Executive Assistant
Background Papers: Held with Author
Ref: q:\ijb\ccgcttee\feb18

Signature: Date: 25 January 2018

Designation: Chief Officer Name: Pamela Gowans

Appendix 1

MORAY INTEGRATION JOINT BOARD

SCHEME OF ADMINISTRATION

Dealing with the Board's Committee Structure and Working Groups

Terms of Reference to Committees:

(A) Audit and Risk Committee
(B) Clinical and Care Governance Committee
(C) Appointments Committee

Terms of Reference to Working Groups:

(1) Strategic Planning and Commissioning Executive Group
(2) Adaptations Governance Group

(A) Audit and Risk Committee

The following has been agreed by the Board for this Committee:

Membership:	2 Council voting members (not chair or vice chair of Board) 2 Health Board voting members (not chair or vice chair of Board) Third Sector Stakeholder Member NHS Grampian Staff Representative Stakeholder Member
Chair:	voting member, rotating every 18 months as a Council voting member and Health Board voting member in line with the term for the Chair of the Board, selected from the organisation which does not currently chair the Board.
Quorum:	2 voting members
To be in attendance:	Chief Officer; Chief Finance Officer; Chief Internal Auditor. Professional advisors and senior managers. External auditor to attend at least two meetings per annum at invitation of Committee. Other persons and advisors to attend at invitation of Committee.
Meeting frequency:	minimum 4 per year, as per annual forward schedule of meetings agreed by Board. There should be at least one meeting a year, or part thereof, where the Committee is given the opportunity to meet the External Auditor and Chief Internal Auditor on an informal basis without other senior officers present. The Committee may arrange additional workshops and training sessions to support its work and development of members.

Remit and powers:

1 To assist the Board to deliver its responsibilities for the conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide assurance to the Board that appropriate systems of internal control are in place to ensure that: business is conducted in accordance with the law and proper standards; public money is safeguarded and properly accounted for; Financial Statements are prepared timeously, and give a true and fair view of the financial position of the Board for the period in question; and reasonable steps are taken to prevent and detect fraud and other irregularities.

2 To review the level of assurance provided over the internal control and corporate governance arrangements (e.g. Standing Financial Instructions – Financial Regulations) of the Board and make recommendations to the Board regarding the signing of the Annual Governance Statement.

3 To approve the selection and appointment of the Board's Internal Audit function.

4 To receive and consider the annual internal and external audit plans on behalf of the Board, and receive reports on work planned, progressed, and completed by Internal and External Auditors.

5 To consider matters arising from Internal and External Audit reports and any investigations into fraud or other irregularities, and review on a regular basis the implementation of actions planned by management in response to these matters.

6 To monitor the effectiveness of the risk management arrangements implemented by the Board, including strategy, assessment, monitoring and reporting of risk.

7 To consider the annual financial accounts and related matters before submission to the Board.

8 To obtain assurance that the Senior Management Team maintains effective controls within their services which comply with financial procedures and regulations.

9 To develop and oversee arrangements for reporting the assurance gained from its activities for the information of the relevant Scrutiny and Audit Committees within NHS Grampian and the Moray Council, and obtaining the assurance it requires from these bodies, including sharing relevant audit reports where appropriate.

10 To set up short term working groups for review work. Membership of the working group will be open to anyone whom the Committee considers will assist in the task assigned. The working groups will not be decision making bodies or formal committees but will make recommendations to the Audit and Risk Committee.

11 To make recommendations regarding improvements to the activities, internal controls and governance of the Board and its services.

12 To maintain awareness of relevant Audit Scotland and other national audit, inspection and regulatory advice, and consider the potential implications of the outcomes of this work for the Board's internal control and governance arrangements.

13 To review the Committee's effectiveness, and consider its development and training needs at least annually.

14 To instruct investigations and call upon officers to give evidence, explanations, or provide written reports as appropriate for the purpose of providing information to assist the Committee in fulfilling its role of advising the Board.

15 To call for investigation of any matter within its remit, and set its own work programme. To be provided with the resources it needs to do so, and to be given full and timely access to information relevant to its function. The Committee may obtain external professional advice where considered necessary.

(B) Clinical and Care Governance Committee

The following has been agreed by the Board for this Committee:

Membership:	1 Council voting member 1 Health Board voting member Carer Stakeholder Member Service User Stakeholder Member Third Sector Stakeholder Member Moray Council Staff rep Stakeholder Member Chief Officer Professional Member Chief Social Work Officer Professional Member Lead Nurse Professional Member GP Lead Professional Member Non Primary medical services Lead Professional Member Dr Graham Taylor Additional Member
Chair:	Health Board voting member
Quorum:	1 voting member
To be in attendance:	Head of Adult Services Head of Primary Care Prevention and Children's Health Services Clinical Governance Co-ordinator The Committee will extend invitations to other groups or representatives as required to address set agenda items or give further insight and assurance around a particular area.
Meeting frequency:	as per annual forward schedule of meetings agreed by Board. In addition development workshops/activities will be held each year.

Remit and powers:

1. To reflect the following core elements of clinical and care governance in the standing items on the Committee's meeting agenda:

    - **Leadership and accountability** Leadership and management Human resources Organisational learning and continuous professional development Supervision and performance appraisal

    - **Safe and effective practice** Risk management and adverse events Research, evidence-based practice and informed decision-making Adult Support and protection Child protection

    - **Accessible, flexible and responsive services** The involvement of people who use services and carers Integrated working

    - **Effective communication and information** Information management Standards, outcomes and audit Complaints and compliments

2. To oversee and provide assurance in regards to clinical and care governance issues within the Moray Health and Social Care services.

3. To provide support and assurance and escalate concerns to the Board.

4. To inform and assure the NHS Grampian Clinical Governance Committee and Chief Social Work Officer, at a frequency to be determined, that robust processes and procedures are in place.

5. An annual report will be submitted to the NHS Grampian Clinical Governance Committee providing Board activity which will evidence robustness in regards to procedures.

6. To support and assist the Board in achieving their clinical and care governance responsibilities in compliance with the Health and Social Care Integration, Clinical and Care Governance Framework Version 1 (Scottish Government November 2014).

7. To provide assurance to partner organisations that robust and effective mechanisms for clinical and care governance are in place for the services and functions delegated.

8. To provide a coordinated and integrated approach to clinical and care governance across Moray Health and Social Care Partnership.

9. To inform, support and advise Health and Social Care staff on clinical and care governance issues, ensuring and enabling best practice and high quality safe patient care.

10. To encourage ownership and collaboration with Health and Social Care staff informing the working of the committee, highlighting issues of concern and good practice.

11. To enable reporting on these matters as part of the annual reporting cycle.

12. To provide assurance to Statutory post holders in relation to effective services – i.e. Medical Director, Executive Nurse Director and Chief Social Work Officer.

13. To feedback on the work of the committee to members' profession/service.

14. To ensure that systems are in place and performing effectively across health and social care to support clinical and care governance including to ensure that registration is current and valid and that there is a system for reporting poor practice by registered professionals to the appropriate regulatory board.

15. Following each meeting, to report to the Board providing details of any governance issues or concerns that the operational teams have reported, as well as evidence of good practice and learning on an exception basis. Where an issue or concern is linked to delivery of a Children's Health Service or an Adult Service out with the Board then the report will also be forwarded to the NHS Grampian Clinical Governance Committee or to the Chief Social Work Officer as appropriate.

(C) Appointments Committee

The following has been agreed by the Board for this Committee:

Membership:	Chair of Board Vice Chair of Board Chief Officer Chief Finance Officer
Chair:	Chair of Board
Quorum:	All members
To be in attendance:	----------
Meeting frequency:	ad hoc, as and when required to fill a vacancy in stakeholder membership.

Remit and powers:

1. To appoint a new stakeholder member to fill a vacancy following the Board's agreed process for identifying potential new members.

(1) Strategic Planning and Commissioning Executive Group

The following has been agreed by the Board for this Working Group:

Membership: Chair of Board
Chief Officer
Joint Operational Manager, Adult Services
Hosted Services Manager
Hospital Manager, Dr Gray's Hospital
Clinical Lead, Primary Care
Clinical Lead, Secondary Care
Housing
Third Sector Representation - tsiMORAY
Private Sector
Locality Representation
Strategic Planning Project Officer
Service Manager, Commissioning Team
Finance Project Manager

Chair: Chief Officer

Quorum: ----------

To be in attendance: ----------

Meeting frequency: as required

Remit and powers:

1. To drive forward the Board's Strategic Plan and translate this into an Implementation Plan that meets the requirements set out in the Public Bodies (Joint Working) (Scotland) Act 2014 in relation to the integration principles and the 9 national health and wellbeing outcomes.

2. To develop an agreed terms of reference and process by which to oversee planning and commissioning on behalf of the Board.

3. To access a range of stakeholders via the Strategic Planning Reference Group.

4. To oversee the strategic plan, steer implementation and the allocation of funds, reporting this activity to the Board on a regular basis.

5. To ensure that all existing contracts put in place by Moray Council and NHS Grampian are reviewed and that necessary stakeholders are brought together to complete the review and agree a process for the future, which will be set out in a Joint Commissioning Strategy that will be brought to the Board for approval.

6. To review locality planning arrangements and develop locality representation.

7. Ongoing monitoring of the Implementation Plan.

(2) Adaptations Governance Group

The following has been agreed by the Board for this Working Group:

Membership: Occupational Therapy representative

Housing Representative

Legal Representative

Finance Representative

Chair: Head of Adult Health and Social Care, Additional Member

Quorum: ----------

To be in attendance: ----------

Meeting frequency: Initially monthly until budget and any process amendment has been agreed and thereafter quarterly

Remit and powers:

1. To identify the correct budget for transfer to the Board.
2. To ensure that the resources identified for adaptations are utilised correctly and efficiently.
3. To keep under review the adaptations process to ensure Best Value is being achieved.
4. To review performance information in relation to adaptations to ensure effectiveness and efficiency.
5. To report to the Strategic Planning and Commissioning Executive Group.

Version History

31 August 2017	Information for Committees and working groups pulled together into Scheme of Administration
31 August 2017	Appointments Committee agreed by Board to appoint stakeholder members.
23 February 2017	Strategic Planning and Commissioning Executive Group remit extended by adding ongoing monitoring of Implementation Plan. Adaptations Governance Group agreed by Board.
10 February 2017	Appointments Committee agreed by Board to select and appoint a Chief Financial Officer. On completion Committee to be disbanded.
10 November 2016	Audit and Risk Committee and Clinical and Care Governance Committee quorum amended.
28 April 2016 and 30 June 2016	Clinical and Care Governance Committee agreed by Board.
31 March 2016	Strategic Planning and Commissioning Executive Group agreed by Board.
31 March 2016	Audit and Risk Committee agreed by Board.

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 2 FEBRUARY 2018**

SUBJECT : **PROPOSED CHANGE TO MEETING DATES 2018/2019**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To propose a change to the schedule of meetings of the Clinical and Care Governance Committee for 2018/19.

2. RECOMMENDATION

2.1 It is recommended that the Clinical and Care Governance Committee agree to recommend to the Moray Integration Joint Board (MIJB) the changes to the schedule of meetings for 2018/19 as attached at APPENDIX 1.

3. BACKGROUND

3.1 A timetable of meetings for the MIJB was agreed at its meeting held on 31 August 2017 (para 9 of the Minute refers).

3.2 Current meetings scheduled are not condusive to clinical availability and representation. In consultation with the Clinical and Care Governance Committee Chair, it has been agreed to propose a change to the schedule of meetings of this Committee to ensure appropriate representation at each meeting.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The proposed change of scheduled dates are attached at **APPENDIX 1**.

4.2 Any revision to meeting dates require agreement by the MIJB.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019.

In terms of the Standing Orders approved by the Board at their meeting on 25 February 2016 (para 7 of the Minute refers), section 4.1, the date, time and frequency of meetings are to be set by the Board.

(b) Policy and Legal

None directly arising from this report.

(c) Financial implications

None directly arising from this report.

(d) Risk implications

None directly arising from this report.

(e) Staffing implications

None directly arising from this report.

(f) Property

None directly arising from this report.

(g) Equalities

None directly arising from this report.

(h) Consultations

Consultations have been undertaken with the following staff who are in agreement with the content of this report where it relates to their area of responsibility:

- Legal Services Manager (Licensing & Litigation), Moray Council
- Caroline Howie, Committee Services Officer, Moray Council
- Professor Amanda Croft, Deputy Chief Executive, NHS Grampian and Chair, MIJB Clinical and Care Governance Committee
- Chief Financial Officer, MIJB
- Chief Officer, MIJB

6. CONCLUSION

6.1 The Clinical and Care Governance Committee is asked to agree recommendation of the proposed change to meeting dates to the MIJB at its meeting in March 2018.

Author of Report:	Catherine Quinn, Executive Assistant
Background Papers:	Held with Author
Ref:	q:\ijb\ccgcttee\feb18

Signature: Date : 25 January 2018

Designation: Chief Officer Name: Pamela Gowans

INTEGRATION JOINT BOARD

MEETINGS TIMETABLE 2018/19

Remainder of Financial Year 2017/18

DATE	TIME	MEETING TYPE	Venue
25 January 2018	9:30am – 12 noon	Board Meeting	Inkwell Main, Elgin Youth Café
2 February 2018	9:30am – 12 noon	Clinical & Care Governance Committee	Spynie Dental Centre
22 February 2018	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café
29 March 2018	9:30am – 12 noon	Board Meeting	AGBC, Elgin
29 March 2018	1:00pm – 2:30pm	Audit & Risk Committee	AGBC, Elgin

Financial Year 2018/19

DATE	TIME	MEETING TYPE	Venue
26 April 2018	9:30am – 12 noon	Board Meeting	Inkwell Main, Elgin Youth Café
~~11 May 2018~~ 31 May 2018	~~9:30am – 12 noon~~ 1.00 – 3.30pm	Clinical & Care Governance Committee	TBC
31 May 2018	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café
28 June 2018	9:30am – 12 noon	Board Meeting	TBC
28 June 2018	1:00pm – 2:30pm	Audit & Risk Committee	TBC
26 July 2018	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café
10 August 2018 30 August 2018	~~9:30am – 12 noon~~ 1.00 – 3.30pm	Clinical & Care Governance Committee	TBC
30 August 2018	9:30am – 12 noon	Board Meeting	TBC
27 September 2018	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café

DATE	TIME	MEETING TYPE	Venue
27 September 2018	1:00pm – 2:30pm	Audit & Risk Committee	Inkwell Main, Elgin Youth Café
9 November 2018 29 November 2018	~~9:30am – 12 noon~~ 1.00 – 3.30pm	Clinical & Care Governance Committee	TBC
29 November 2018	9:30am – 12 noon	Board Meeting	TBC
13 December 2018	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café
13 December 2018	1:00pm – 2:30pm	Audit & Risk Committee	Inkwell Main, Elgin Youth Café
31 January 2019	9:30am – 12 noon	Board Meeting	TBC
8 February 2019 28 February 2019	~~9:30am – 12 noon~~ 1.00 – 3.30pm	Clinical & Care Governance Committee	TBC
28 February 2019	9:00am – 12 noon	Development Session	Inkwell Main, Elgin Youth Café
28 March 2019	9:30am – 12 noon	Board Meeting	TBC
28 March 2019	1:00pm – 2:30pm	Audit & Risk Committee	TBC

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 2 FEBRUARY 2018**

SUBJECT : **ANNUAL ASSURANCE REPORT TO NHS GRAMPIAN CLINICAL GOVERNANCE COMMITTEE**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To note the annual assurance report submitted, on behalf of Moray Integration Joint Board (MIJB) Clinical and Care Governance Committee, to NHS Grampian's Clinical Governance Committee in November 2017.

2. RECOMMENDATION

2.1 It is recommended that the Clinical and Care Governance Committee consider and note the annual assurance report submitted in November 2017, as attached at APPENDIX 1.

3. BACKGROUND

3.1 The Clinical and Care Governance Committee provides assurance to the NHS Grampian Clinical Governance Committee that the MIJB and its Clinical and Care Governance Committee has robust processes and procedures in place to fulfil its governance responsibilities.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 An annual assurance report was submitted to the NHS Grampian Clinical Governance Committee since the last meeting of this Committee, in November 2017.

4.2 The report provides an update on MIJB activity which evidences our robustness with regard to governance processes.

5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019.

All activities governed under the Clinical and Care Governance Framework must satisfy the aims of the strategic plan of the MIJB.

(b) Policy and Legal

The IJB agreed that the Clinical and Care Governance Committee shall inform and assure NHSG Clinical Governance Committee that robust processes and procedures are in place. This is set out in the IJB's Admin Scheme, section (B)(4).

(c) Financial implications

None directly arising from this report.

(d) Risk implications

None directly arising from this report.

(e) Staffing implications

None directly arising from this report.

(f) Property

None directly arising from this report.

(g) Equalities

None directly arising from this report.

(h) Consultations

Consultations have been undertaken with the following staff who are in agreement with the content of this report where it relates to their area of responsibility:

- Legal Services Manager (Licensing & Litigation), Moray Council
- Caroline Howie, Committee Services Officer, Moray Council
- Chief Financial Officer, MIJB
- Chief Officer, MIJB

6. CONCLUSION

6.1 The annual assurance report was submitted in November 2017 to NHS Grampian's Clinical Governance Committee.

Author of Report:
Background Papers:
Ref:

Signature: Date: 26 January 2018

Designation: Chief Officer Name: Pamela Gowans

APPENDIX 1

MORAY INTEGRATION JOINT BOARD

Report to NHS Grampian Clinical Governance Committee

Introduction

This report aims to provide assurance to the NHS Grampian Clinical Governance Committee that the Moray Integration Joint Board (MIJB) and its Clinical and Care Governance Committee have fulfilled their responsibilities and that there are appropriate and agreed governance arrangements in place.

This allows the representative members from both organisations to have open and transparent discussions and highlight and escalate concerns appropriately.

The Clinical and Care Governance Framework for the MIJB was agreed and implemented in April 2016. The arrangements described in the framework are designed to assure the MIJB, NHS Grampian and Moray Council that the quality and safety of services delivered, and the outcomes achieved from the delivery of those services, are the best for the people of Moray.

The framework is attached at **APPENDIX 1** and members are asked to note that this framework will continue to be updated to reflect experience of joint working and as service delivery models change and evolve.

Aim

This paper will provide the Committee with assurance and information on the Clinical Governance arrangements within Moray.

Clinical & Care Governance Committee

The agenda for each Committee is formed of standing items, which includes the minutes and items escalated from the functioning Clinical and Care Governance Operational Groups. The agenda setting process is being revised to ensure the agenda is structured to reflect key priorities, with information collated to allow for easier scrutiny.

Reports for the Committee's consideration over the past year have included Falls Action Plan, consultation on new National Health and Social Care Standards and Health and Safety (including a progress report on HSE Improvement Notice work).

Routinely papers are scrutinised by the Committee and the Chair whilst the Clinical Governance Facilitator attends to respond to any issues and receive support and direction from the Committee. The Committee also receive data on Adverse Events and Feedback from both Health and Social Care Services.

Our standing items of adverse events and feedback and service self-assessments have highlighted the following in 2017:

Adverse Events and Feedback: adverse events and feedback from both Health and Social Care is scrutinised by the Committee at every meeting. There has been a further emphasis on reporting incidents within provider services and consequently reporting has improved. In the first two quarters of 2017, the number of incidents has decreased, with most incidents resolved with a local review by the line manager in discussion with staff.

Self-Assessments: All services are asked to undertake a self-assessment of their clinical governance arrangements and to present these to the MIJB Clinical and Care Governance Committee. This is done on a rolling programme basis throughout the year. The self-assessment templates are attached at **APPENDIX 2**. This approach has been effective in supporting the review of governance arrangements across the MIJB. The process highlights issues the Committee may wish to consider in relation to particular statements and poses questions members may want to ask of staff to seek assurances.

Some further changes are taking place to enhance the effectiveness of the Clinical and Care Governance Committee: increasing the quorum, incorporating agenda setting meetings prior to the Committee meeting and an annual report to the MIJB in addition to the minutes already submitted quarterly. This will be reflected in the framework revision.

Clinical & Care Governance Operational Groups

The pre-existing CHSCP groups have been reviewed in 2017, broadening membership and enhancing reporting processes. The revised operational arrangements were agreed at the last meeting of the Clinical and Care Governance Committee.

There is a clear understanding of the need for greater transparency and assurance and improving the quality of patient/service user experience. The key principles of the operational groups are:-

- Assurance of consistent standards and maximising shared learning in cross system working.
- Building quality improvement capability and support to Clinical Leads and Managers as a priority.
- Supporting resources are finite and should be effectively targeted around agreed strategic priorities using the most effective improvement methods.
- Regular planned monitoring of the effectiveness of local arrangements.
- To monitor the Risk Register from a health and care governance perspective and escalate to the MIJB any unresolved risks that require executive action or that pose significant threat to patient care, service provision or the reputation of the MIJB.
- To ensure that mechanisms are in place for services to routinely listen, learn and develop from service user experience.
- To ensure that quality and self-evaluation mechanisms are in place to inform a culture of continuous improvement.

In order to advance a more robust and transparent process, underpinning the above principles, it has been agreed that all services will report monthly using the Sector Reporting Framework template which has been implemented by NHS Grampian's Clinical Governance Unit. The template has been designed to straightforwardly track progress against issues/areas of concern, record good practice and easily evidence actions being taken.

Furthermore, to enhance our scrutiny, an Adverse Events Review Group (AERG) has recently been established to provide evidence and assurance that adverse events are being addressed appropriately. The AERG will also identify training needs and shared learning arising from the review of adverse events.

Key Risks

There is a risk that the governance arrangements developed are not sufficiently robust to identify, mitigate and escalate issues of concern related to the safety and quality of care provided by services delegated to the MIJB.

Overcoming challenges of transformational change, including shifting the balance of care from the acute setting into the community and an integrated approach to the provision of health and social care services are the focus of drivers for change that the MIJB has taken account of in establishing its system of clinical governance and risk management assurance.

The links between the MIJB Strategic Risk Register and Operational Risk Registers are being further developed and reviewed to test risk mitigation and to promote continuous improvement.

A performance management framework is being developed over the next few months which will include clinical quality indicators to enhance assurance.

Conclusion

While we are confident that the processes required are in place, we continue to develop our Committee and Operational Groups to ensure the breadth of business undertaken is focused on the core elements of clinical and care governance. The controls in place are adequate and operating effectively but will continue to be reviewed to identify opportunities for improving processes and practices which will benefit future clinical governance activities.

Recommendation

The Clinical Governance Committee is requested to note the content of the report and be assured the processes and commitment of both the Committee and the Group membership and leadership are in place.

Pam Gowans
Chief Officer, MIJB
9 November 2017

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 2 FEBRUARY 2018**

SUBJECT : **UPDATED CLINICAL AND CARE GOVERNANCE OPERATIONAL ARRANGEMENTS**

BY: **HEAD OF ADULT SERVICES AND SOCIAL CARE & HEAD OF PRIMARY CARE, SPECIALIST HEALTH IMPROVEMENT AND NHS COMMUNITY CHILDREN'S SERVICES**

1. REASON FOR REPORT

1.1 To provide an update on the operational clinical and professional governance arrangements, incorporating the Grampian Mental Health and Learning Disabilities structure.

2. RECOMMENDATION

2.1 That the Clinical and Care Governance Committee consider and note the updated operational clinical governance arrangements which now incorporates specific reference to the Grampian Clinical and Care Governance Leadership Group for Mental Health and Learning Disabilities Services.

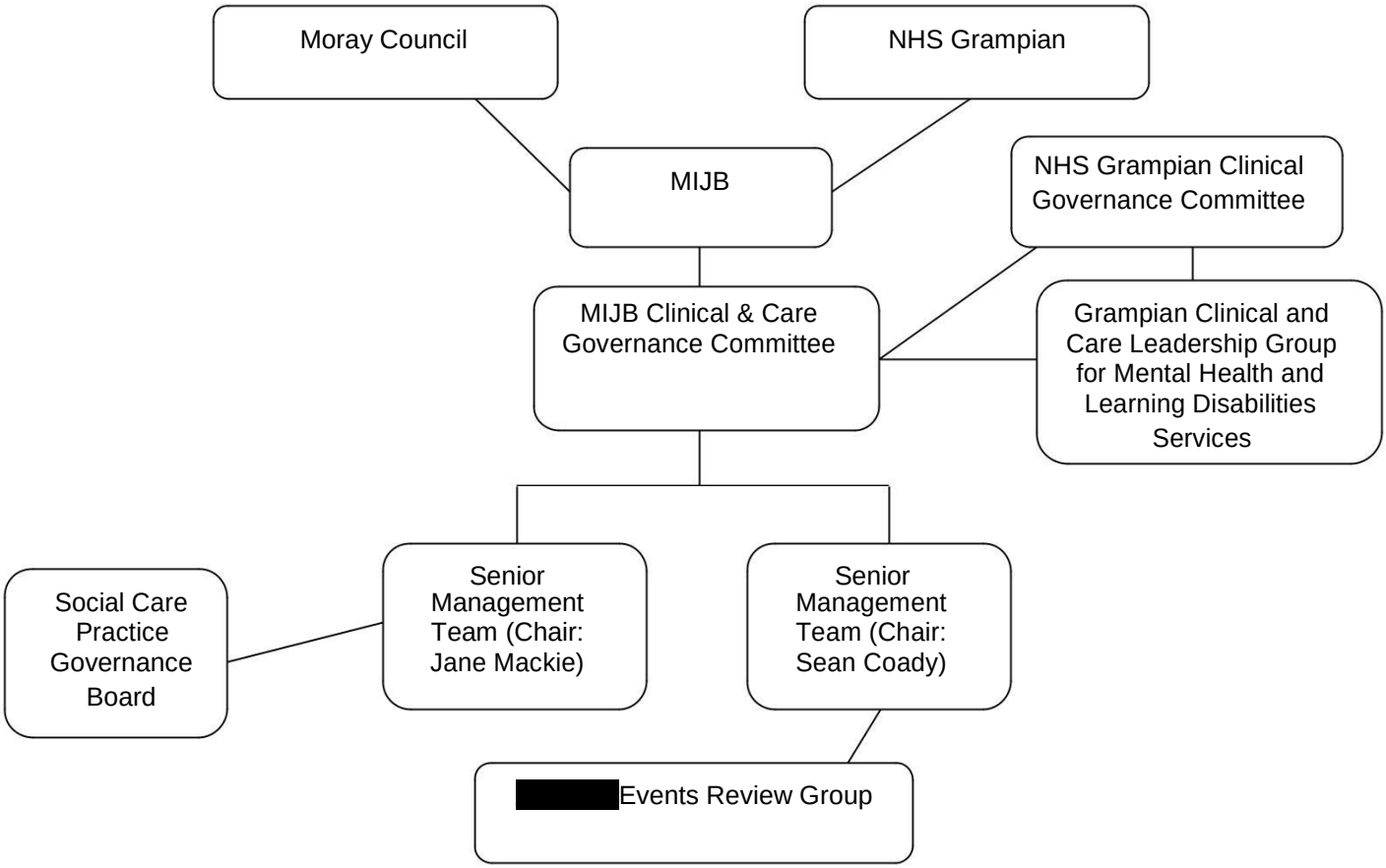
3. BACKGROUND

3.1 The operational clinical and care governance arrangements was presented to the Clinical and Care Governance Committee on 3 November 2017 (Para 6 of the draft Minute refers). It was requested at this meeting to amend the report to incorporate and reflect the Grampian Clinical and Care Leadership Group for NHS Grampian's Mental Health and Learning Disabilities services. The group is established as the clinical and professional governance assurance committee for NHS Grampian's Mental Health and Learning Disabilities services, reporting directly to the NHS Grampian Clinical Governance Committee.

3.2 Mental Health and Learning Disabilities Services are delegated to the Moray Integration Joint Board (MIJB) with oversight by this Committee but the NHS Grampian Board and Moray Council are obligated to continue their governance responsibility for service users receiving care and therefore its speciality is retained alongside the Moray Integration Joint Board.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The diagram below sets out the amended reporting and assurance arrangements:



5. SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019.

As set out within Annex C of the Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 Clinical and Care Governance Framework.

(b) Policy and Legal

Clinical and Care Governance requirements are set out within the Moray Health and Social Care Integration Scheme. Appropriate arrangements must be in place to ensure and evidence good governance in meeting duties under the Public Bodies (Joint Working) (Scotland) Act 2014.

(c) Financial implications

None directly associated with this report.

(d) Risk implications

Moray IJB, Moray Council and NHS Grampian could find themselves exposed to significant risks if good governance is not in place. The purpose being to oversee the processes to ensure that appropriate action is taken in response to adverse events, scrutiny reports/action plans, safety action notices, feedback, complaints and litigation, and those examples of good practice and lessons learned are disseminated widely.

(e) Staffing implications

This activity is core to all practitioners in the front line both in terms of their professional competence and assurances in care delivery.

(f) Property

None directly arising from this report.

(g) Equalities

None directly arising from this report.

(h) Consultations

Consultations have been undertaken with the following staff that are in agreement with the content of this report where it relates to their area of responsibility:

- Legal Services Manager (Licensing & Litigation)
- Caroline Howie, Committee Services Officer
- Liz Tait, NHS Grampian Clinical Governance Lead
- Dr Ann Hodges, Secondary Care Medical Advisor to MIJB

6. CONCLUSION

6.1 The Committee should note the updated operational reporting arrangements to effectively address clinical governance arrangements in terms of reporting and assurance.

Author of Report: Catherine Quinn, Executive Assistant
Background Papers: Held with author
Ref: MIJB/Clinical & Care Governance Cttee/Feb18

Signature: _____ Date: 26 January 2018

Designation: Chief Officer Name: Pamela Gowans

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 2 FEBRUARY 2018**

SUBJECT : **DUTY OF CANDOUR CONSULTATION**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To advise the Clinical and Care Governance Committee on new Duty of Candour provisions being implemented from 1 April 2018.

2. RECOMMENDATION

2.1 It is recommended that the Clinical and Care Governance Committee consider and note the new Duty of Candour (DoC) arrangements being implemented from 1 April 2018.

3. BACKGROUND

3.1 The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 received Royal Assent on 1 April 2016 and introduced a new organisational duty of candour on those providing health, care and social work services. The implementation date for the DoC to come into effect is 1 April 2018.

3.2 The overall purpose of the new duty is to ensure that listed responsible bodies, which include Moray Council and Grampian Health Board, are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm, as defined in the Act. This duty requires responsible bodies to follow a DoC procedure which will include notifying the person affected, apologising and offering a meeting to give an account of what happened. The procedure will also require the body to review each incident and offer support to those affected (people who deliver and receive care). The details of this procedure will be set out in Regulations which will be published prior to 1 April 2018 along with guidance.

3.3 The following incident outcomes will trigger the DoC procedure:

- Death
- Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (severe harm)

Harm which is not severe but which results in:

- An increase in the person's treatment
- Changes to the structure of the person's body
- The shortening of life expectancy
- Impairment to the sensory, motor, physiologic or intellectual functions which has or is likely to last for a continuous period of at least 28 days
- The person experiencing pain or psychological harm which has or is likely to last for a continuous period of at least 28 days
- The person requiring treatment by a registered health professional in order to prevent death

3.4 The DoC procedure involves taking actions to meet up with, and apologise to the service user / or those acting on their behalf, and provide support for them. The Act makes it clear that apologising in relation to the DoC cannot be taken by itself as an admission of negligence or a breach of statutory duty, but this will not prevent individuals affected from taking further action in relation to the incident. There will be a significant requirement to keep detailed records of the apology, each meeting and any actions taken at the meeting or as a result of the meeting.

3.5 To support responsible bodies to meet these new requirements the Scottish Government, Healthcare Improvement Scotland (HIS), the Care Inspectorate (CI), Scottish Social Services Council (SSSC) and NHS Education for Scotland (NES) are working in partnership with a wide range of stakeholders to design and develop education and training resources and monitoring requirements to support bodies to meet the new statutory duty of candour.

3.6 Moray Council and Grampian Health Board, as listed bodies covered by the The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 will be required to prepare and publish annual reports, which must contain the following information:-

- Details about the incidents that have occurred, and to which the DoC applied
- Information on the organisations compliance with the DoC procedure
- Information about policies and procedures for identifying and reporting incidents and support available to staff and persons affected by incidents
- Information relating to whether there have been changes to these policies resulting from incidents that have occurred.

4.0 KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 As CI and HIS already have existing systems for regulated health and social care services, the intention is to align existing processes and systems as far as possible to minimise paperwork whilst still ensuring that the organisational duty is being applied through a culture of openness and learning. Specific guidance including how bodies are to operate the duty of candour has not yet been published but is likely to include more details about:-

- The notification to be given by the responsible person;
- The apology to be provided by the responsible person to the relevant person;
- The actions to be taken by the responsible person to offer and arrange a meeting with the relevant person, including asking the relevant person whether the relevant person wishes to receive an account of the incident or information about further steps taken;
- The actions which must be taken at, and following, such a meeting;
- An account of the incident, information about further steps taken and any other information to be provided by the responsible person;
- The form and manner in which information must be provided;
- The circumstances in which the responsible person is to make available, or provide information about, support of persons affected by the incident;
- The keeping of information by the responsible person; and
- Steps to be taken by the responsible person.

4.2 A dedicated webpage available at the following link (http://www.gov.scot/Topics/Health/Policy/Duty-of-Candour) has been produced by the Scottish Government. This includes more information on regulations and guidance, examples of DoC and Frequently Asked Questions.

5.0 SUMMARY OF IMPLICATIONS

(a) Moray 2026: A Plan for the Future, Moray Corporate Plan 2015 – 2017 and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

As defined within the Moray Integration Scheme values and meeting the strategic aims contained within the MIJB Strategic Plan 2016-2019.

(b) Policy and Legal

Being open and honest with people about harm caused as a result of healthcare is a key part of existing policy and processes. Indeed it is already a professional duty of all healthcare professionals. However the responsible body will be responsible for providing training and support to those carrying out the DoC procedure. Whilst the Integration Joint Board is not itself a listed body, given its operational oversight role for integrated health and social care services it needs to assure itself as to the arrangements put in place within both Moray Council and NHS Grampian for Health and Social Care Moray staff.

(c) Financial implications

None directly associated with this report. .

(d) Risk Implications and Mitigation None

directly associated with this report.

(e) Staffing Implications

None directly associated with this report.

(f) Property

None directly associated with this report.

(g) Equalities

An Equality Impact Assessment (EIA) is not needed because the report concerns implementation of legislation.

(h) Consultations

Consultation on this report has taken place with the following staff who are in agreement with the content in relation to their area of responsibility:-

- Legal Services Manager (Litigation & Licensing), Moray Council
- Caroline Howie, Committee Services Officer, Moray Council
- Chief Financial Officer, MIJB
- Chief Social Work Officer, Moray Council
- Professional Lead for Clinical Governance, NHS Grampian
- Head of Adult Services and Social Care
- Head of Primary Care, Specialist Health Improvement and NHS Community Children's Services

6.0 CONCLUSION

6.1 The details of this procedure will be set out in Regulations which will be published prior to 1 April 2018. Staff briefings and the cascading of information to staff will continue to take place over the next few months.

Author of Report: Catherine Quinn, Executive Assistant
Background Papers: With author
Ref: ijb\CCG\Feb18

Signature: _____ Date: 25 January 2018

Designation: Chief Officer Name: Pam Gowans

Re-audit of Elgin Young Person's Diabetes Clinic User Experience: December 2016 – February 2017

Report Published: October 2017

AUTHOR(S) Edna Stewart [(1)], Sarah Norris[(2)]
[(1)]Senior Diabetes Specialist Nurse (Young People) Diabetes Centre, David Anderson Building, [(2)]Clinical Effectiveness Facilitator, Quality, Governance and Risk Unit, NHS Grampian

Contact: Linda Caie, NHSG Diabetes & Heart Failure Nurse Manager
linda.caie@nhs.net

INTRODUCTION

The initial Young's Person's Diabetes Clinic audit took place in 2009 in Aberdeen and Fraserbugh followed by a re-audit in 2012, with the aim to obtain feedback from patients attending the Young Persons' Diabetes Service Clinic (YPC). In 2013, the first Elgin Young Person's Service evaluation took place, aimed specifically at those young people who have completed transition from the Paediatric Service to the Young People's Service in the last 12 months. The 2013 audit identified areas for improvement, with planned implementation by early 2014, to improve equity in service. This audit took place to ensure previous changes have been beneficial to both the young people and the Diabetes Specialist Nurses (DSN).

AIM:
To receive information to facilitate the improvement of Young Person's Diabetes Service in Elgin as part of Moray Diabetes Nursing Improvement plan.

Objectives:

- To ensure equity of service for Young People with Diabetes across NHSG
- To evaluate current transition from Paediatric Service to Young People's Service
- To evaluate clinic process for Young People in Moray

METHOD

The 2012 questionnaire was altered with help from the Clinical Effectiveness Team, to reflect changes that had taken place and piloted at one clinic. The questionnaires were due to be handed out to attendees during November 2016 through to January 2017. No December clinic appointments were sent out, due to an administration error, therefore questionnaires were handed out at the February clinic. The questionnaire comprised of 2 sections; Section 1 for completion whilst waiting, and Section 2, to be completed after the consultation/before leaving the clinic. Attendees who preferred to complete the questionnaire in their own time were provided with a free-post envelope to return the questionnaire.

It is recognised that for the clinics being audited, the total number of attendees would not reflect the total number of questionnaires handed out, as some attendees potentially would attend more than once over this period and would have completed the questionnaire at a previous attendance.

RESULTS (n=9) Response rate = **69.2%**: **9** questionnaires returned from **13** handed out. For the 2013 audit 28 responses were received from 45 attendees, a 62.2% response rate

Section 1: To be completed whilst waiting to be seen

Q1: How old are you?

Age	2017 (n=9)	2013 (n=28)
16 or less	33.3%	14.3%
17 -19	33.3%	67.9%
20+	33.3%	17.9%

Q2: Are you Male or Female?

Age	2017 (n=9)	2013 (n=28)
Male	55.5%	46.4%
Female	33.3%	50.0%
Not answered	11.1%	3.6%

Q3: Are you...? Multiple response

	2017 (n=9)	2013 (n=28)
Still at school	22.2%	14.3%
At University/College	44.4%	28.6%
In Full-Time employment	22.2%	25.0%
In part-Time employment	11.1%	28.6%
Not currently working	11.1%	14.3%

Q4: Do you live ....?

	2017 (n=9)	2013 (n=28)
With your parents/carer	77.7%	77.4%
With spouse/partner	0.0%	6.5%
With friends/roommate	0.0%	0.0%
Alone	11.1%	3.6%
Live with other	11.1%	0.0%
No data	0.0%	3.6%

Q5: At what age were you first diagnosed with diabetes?

- 12 months old
- 22 months old
- 24 months old
- 6 years old
- 8 years old
- 9 years old
- 9 years old
- 12 years old
- 13 years old

Q6: Which Hospital were you attending when you were diagnosed with diabetes

Hospital	2017 (n=9)	2013 (n=28)
Royal Aberdeen Children's	22.2%	3.6%
Dr Gray's	55.5%	85.7%
Other:	22.2%	10.7%

Q7a: How long have you been attending the Young Person's Diabetes Service Clinic?

	2017 (n=9)	2013 (n=28)
Less than1 year	-	32.1%
More than 1 year	-	57.1%
Less than 3 years	33.3%	-
More than 3 years	66.6%	-
No data	-	10.7%

Q7b: Prior to attending the YPC which Hospital were you attending for the management of your diabetes? (n=3) i.e. those attending <3 years.

Results are not displayed due to potential identifiable data. This question was more applicable for the audit undertaken at RACH, and not applicable for the small numbers involved at Dr Gray's.

Q7c: If you transferred from the Children's Service within the last 3 years, please comment on the process e.g. your understanding, explanations, smoothness. (n=3)

- Smooth, well explained, everyone was helpful
- It went well during transfer
- No comment made

Q7d: Indicate which of the following took place pre-transfer? (n=3) *–establishing if the process has improved.*
(Multiple response)

	2017 (n=3)	2013 (n=28)
Chat with hospital doctor to discuss any concerns you had about transfer	22.2%	28.6%
Informal visit to see new clinic and meet staff	22.2%	32.1%
Joint meeting with new and previous staff	22.2%	32.2%
Written information of new service and contacts prior to transfer	-	21.4%
Group education/planning session prior to transfer	-	3.6%

Q8a: Have you received contact information from the clinic team members? *2017 Data Only*

Responses vary not all responses from same attendee

	Yes	No	Not sure
Diabetes Specialist Nurse	77.7%	-	22.2%
Doctor/Consultant	66.6%	-	22.2%
Dietitian	66.6%	-	33.3%

Q8b: When did you receive contact information from team members (Multiple response)

	2017 (n=9)	2013 (n=28)
Before leaving the Children's Clinic	-	57.1%
At your first Young Person's Clinic	77.7%	17.9%
Have not received information yet	-	-
At another time	11.1%	-
Can't remember exactly	11.1%	10.7%
Not answered	11.1%	

Young Person's Service

Q9a: Which Clinic(s) do you currently attend? (Multiple response)

	2017(n=9)	2013 (n=28)
Young Person's Clinic (David Anderson Building Dr's Gold, Mayo and Others)	-	-
Dr Gray's Hospital (Dr Strachan)	66.6%	53.6%
Dr Gray's Hospital (Dr Park)	-	3.6%
Dr Gray's Hospital (Both Dr Stachan and Dr Park's Clinic	-	14.3%
Young Person's Clinic in Elgin (Dr Strachan)	44.4%	28.6%
Fraserburgh (Dr Watson)	-	-
Diabetes Nurse Led clinic	11.1%	-
Don't know	-	-

Q9b: How often to do you attend the clinic(s) identified above? (Multiple response) *2017 Data Only*

Frequency of visits	Number (%)
Diabetes Specialist Nurse 2 monthly	1 (11.1%)
Consultant Clinic 3 monthly	4 (44.4%
Consultant Clinic 6 monthly	3 (33.3%
Yearly	1 (11.1%
Not answered	1 (11.1%

Q9c: Who did you see at your last Diabetes Clinic Appointment (Multiple response) *2017 Data Only*

	Number (%)
Consultant	9 (100%)
Diabetes Specialist Nurse	6 (66.6%)
Dietitian	3 (33.3%)

Q9d: Since that last clinic appointment, have you seen/contacted any other health professionals in relation to your diabetes? *2017 Data Only*

Doctor:
No

Not answered

Diabetes Nurse: x 2 Text/phone: how I am getting on Needed advice
x 1 (No additional information)
x 4 x 2

Q10: How often do you see the Dietitian in the Diabetes Clinic?

Frequency	2017 (n=9)	2013 (n=28)
At each clinic visit	44.4%	25.0%
Whenever I want	22.2%	28.6%
Only if I ask	22.2%	32.1%
Never	11.1%	7.1%
No data	-	7.1%

Out of Hours support

Q11: If you need advice about your diabetes 'out of hours' who do you contact?

	2017 (n=9)
NHS 24	33.3%
Ward	-
Diabetes Specialist Nurse	55.5%
Accident and Emergency	-
Not answered	11.1%

Have you accessed the Diabetes Service out of hours?	2013 (n=28)
Yes	14.3%
No	85.7%

Q12a: If you sought assistance. How easy was it to get advice?(n=8)

	2017 (n=8)	2013 (n=4)
Very Easy	-	25.0%
Easy	50.0%	50.0%
Difficult	-	25.0%
Very Difficult	-	-
Not applicable	37.5%	-
Not indicated	12.5%	-

Comments: One phone call
Haven't needed to

Q12b: Did the advice given solve your query? (n=4)

	2017 (n=9)	2013 (n=28)
Yes	100.0%	100.0%
No	-	-
Not sure	-	-

Q13: Which method(s) would you prefer to contact your Diabetes Specialist Nurse? (Multiple response)

	2017 (n=9)	2013 (n=28)
Text	11.1%	57.1%
Telephone	88.8%	60.7%
e-mail	22.2%	14.3%

Q14: How would you prefer to get information about Diabetes? (Multiple response) *2017 Data only*

	2017 (n=9)
Verbally in Diabetes Clinic	4 (44.4%)
Drop in Sessions	-
Leaflets in the Diabetes Clinic	3 (33.3%)
On-line	2 (22.2%)
1 :1 with a Health Professional	2 (22.2%)
Other method	-
Not sure	2 (22.2%)

Q15: Which of these topics would you be of interest in managing your diabetes (Multiple response)

	2017 (n=9)	2013 (n=28)
What's new in Diabetes	88.8%	78.6%
Insulin treatment/delivery options	44.4%	71.4%
Contraception/Family Planning	-	21.5%
Alcohol/Drugs	22.2%	35.7%
Carbohydrate Counting	22.2%	57.1%
Cooking	11.1%	50.0%
Stress Management	66.6%	50.0%
Exercise/Sport	44.4%	53.6%
Going to College/University	22.2%	42.9%
Starting Work	22.2%	-
Other topic	-	-

SECTION 2: To be completed when you have finished in clinic today

Q16: Who would you like to see routinely at the Diabetes Clinic? Multiple response:

	Always		When needed		Never	
	2017 (n=9)	2013 (n=28)	2017 (n=9)	2013 (n=28)	2017 (n=9)	2013 (n=28)
Diabetes Consultant/Doctor	66.6%	71.4%	33.3%	25.0%	-	
Diabetes Specialist Nurse	55.5%	64.3%	44.4%	32.1%	-	3.6%
Dietitian	-	7.1%	88.8%	67.9%	-	21.4%

Q17: Who did you have a consultation with at the Diabetes Clinic today? Multiple response (n=9)
(1 patient did not respond) *2017 Data Only*

	Number (%)
Diabetes Consultant/Doctor	77.7%
Diabetes Specialist Nurse	66.6%
Dietitian	-

Q18: Satisfaction questionnaires previously identified these qualities that attendees valued in health professionals; were they evident today? Please say how many of the staff were.....

1 patient did not answer any of the questions

	Very Important /Important combined % in 2013 (n=28)	Displayed by All staff today 2016/7 (n=9)
Open and Honest	96.4%	77.7%
Knowledgeable	96.5%	88.8%
Easy to talk to	89.3%	88.8%
Respectful of your ideas	92.9%	66.6%
Respectful of your lifestyle	96.4%	77.7%
Supportive	89.3%	77.7%
Not critical	89.3%	66.6%
Listened to what you had to say	-	88.8%
Treated you as an individual	-	66.6%
Helped set goals for care of your diabetes	78.6%	88.8%

Q19: What do you consider to be important when attending the Diabetes Clinic? *Rate by importance to you.*

2017 = '17 (n=9) 2013 = '13 (n=28)	Very important %		Important %		Not Important %		Not answered %	
	'17	'13	'17	'13	'17	'13	'17	'13
Short waiting time before initially being seen	33.3	60.7	33.3	25.0	11.1	10.7	22.2	3.6
Short wait between each health professional	22.2	-	44.4	-	11.1	-	22.2	-
See Diabetes Team without parents (if desired)	33.3	28.6	11.1	35.7	44.4	32.1	11.1	3.6
See the same Doctor at each visit, if possible	55.5	39.3	22.2	53.6	22.2	3.6	-	3.6

Q20: If you have any comments or suggestions about the Diabetes Service for Young People. Please add them below:
None of the respondents provided any additional comments

DISCUSSION

From the response rate of **69.2%**, (9/13) it is hoped that the changes that have taken place since the 2013 have been of benefit to both the young people attending and the Diabetes Team.

2016/17Attendees Response rate:

Clinic	Booked	Attended	DNAs	Questionnaires	
				Handed Out	Previously Completed
November	8	6	2	6	-
December	-	-	-	-	-
January	12	7	5	3*	3
February	7	5	2	4	1
TOTAL	**27**	**18**	**9**	**13**	**4**

* 1 attendee declined to complete a questionnaire

Section1: 2016/17 results (2013 results where applicable are in brackets)

Demographics/and attendance details

- There were a greater number of males responding than females compared to 2013.
- The age groups were evenly split at 33.3% compared to 2013, where the biggest age group was 17-19 years olds (67.9%)
- There were fewer school age attendees and a greater number attending College/ University which is expected if it is the same population
- There were a similar number of attendees who were living with their parents/carer 77.7% (77.4%)
- The age of attendees when they were first diagnosed was similar to 2013, and it may well be the case that the majority are the same clients.
- There was a mixture as to which hospital they were diagnosed at, similar to the 2013 audit

33.3% (3) of attendees had been attending the clinic for less than 3 years. **66.6%** (2) had been transferred from the Children's Service at Dr Gray's, both commenting that it had gone well and smoothly. In 2013, there were questions about what would have been useful pre-transfer, e.g. a chat about any concerns, informal visit, joint meeting. In response to these comments, and within the improvement plan, joint working of health professionals from both services, prior to the patient being transferred was added.

To establish if these changes were in place, for the 2016/17 audit additional questions were added. There were variations as to what happened pre-transfer, those attendees (2) who had transferred since 2013, had an informal visit and a joint meeting. Only one of the two had a chat with the doctor to discuss any concerns about the transfer. This identifies that the actions from 2013 had been implemented. The third attendee had come from a hospital out-with Grampian. Contact information should be provided to all attendees., and in 2016/17 audit, **44.4%** (4) stated that they had received contact details from all three (DSN, Doctor/Consultant and Dietitian), **33.3%** (3) had received information from 2 of the 3 health professionals and **11.1%** (1) had just received the Dietitian's details and was unsure about the others and the last attendee was unsure whether they had received any contact information.

In 2013, **57.1%** attendees received the information before leaving the Children's Clinic. Since 2013 a transition nurse led clinic has been set up, where the Paediatric DSN and the Young People DSN meet with the patients, before moving on up to the Young Person's Clinic. It is not clear whether the **77.7%** (7) of attendees who stated in 2016 that they had received the information when they attended their first Young Person's clinic, were thinking of the transition

clinic, as they should all receive information before leaving the Children's clinic and this is supported by **0.0%** stating that they had not received it *"Before leaving the Children's Clinic***".**

From the results it appears that each team member provides individual contact numbers and perhaps the contact detail process could be further improved by compiling one contact sheet with all the relevant details.

100% of responders stated that they attend only clinics in Dr Gray's which is the same as the 2013 results. Attendance frequency for **77.7%** (7) was 3 or 6 monthly and in addition **11.1%** (1) also attended a DSN clinic every 2 months.

The 2017 audit asked who the attendees had seen at their last clinic appointment, **22.2%** (2) had seen all 3 members of the team, **44.4%** (4) had seen the Consultant and DSN, **11.1%** (1) had seen the Consultant and Dietitian and **22.2%** (2) had seen the Consultant. Who patients see at each visit varies. They do all see the Consultant/Doctor and the DSN or Dietitian as recommended or at the patient's request. It does depend on how busy the clinic is, and in some cases the DSN is asked to see a patient if the doctor is busy, and the doctor following consultation with the patient, may suggest that they see the DSN or Dietitian whilst in clinic. Who they would like to see routinely at the clinic is discussed later.

33.3% (3) had seen the Dietitian at their last clinic appointment. In relation to this, responders were asked how often they see the Dietitian in clinic, **44.4%** (4) stated they had seen the Dietitian *"At each visit",* (25.0% in 2013). **22.2%** (2) saw the Dietitian, "*Whenever I want"* similar to 28.6% in 2013 and **22.2%** "*Only if I ask*" compared to 32.1% in 2013 and **11.1%** (1) *"Never",* (7.1% in 2013). **0.0%** (0) of responders stated they would "*Always*" want to see the Dietitian; **88.8%** (8) would see *'when needed'*. It would appear therefore that who they want to see and who they should see from an attendee's and a clinician's perspective varies.

A further action from the 2013 audit was to review Dietetic input and arrange education sessions for young people. This currently has not taken place. Perhaps further discussion and raising awareness as to the importance of seeing each clinician needs to be reviewed, especially during the early transition stage. During this time the patients are still growing, and their lifestyle is perhaps changing. Interestingly in the 2016/17 audit, on the day they completed their questionnaire, none of the attendees had a consultation with the Dietitian, even though opportunities to access the Dietitian have improved since the 2013 audit, as at that time there was a reduced service.

33.3% (3) responders stated that they had contacted a health professional in relation to their diabetes. **14.3%** (4) in 2013 had accessed the service '*Out of Hours*'. **22.2%** (2) had contacted the DSN, since their last clinic appointment, proving that the contact information works, and another had contacted their doctor. For '*Out of Hours*' support **33.3%**(3) stated they would contact NHS 24; interestingly they had all received the clinical team contact details and **55.5%** (5) would contact the DSN, **3** of which had contact details and **2** did not.

The advice given to patients for Out of Hours (OOH) support is to contact NHS 24. DSNs are not available for OOH support and there is no specific guidance for "Young Adults" which would be similar to the "Guideline for Management of Children with Diabetes (NHSG), where Ward Nurses log calls and hand the sheet to the DSN daily. There are no plans to provide a similar OOH service currently.

All **4** who sought advice stated it was easy to contact the DSN and NHS 24 and all stated that the advice given solved their query the same as in 2013. When asked which method they would prefer to use for obtaining advice, **88.8%** (8) stated they would prefer the telephone. This highlights the benefits of having someone at the end of a phone. It is worth considering perhaps having the ward as an option (24 hour) as DSNs are not "On Call". Discussions are taking place looking at various potential options for patients being able to obtain OOH advice from "local clinic team members", including utilising evening clinic opportunities.

When asked in 2013, "*Would it be useful to be able to contact your DSN by...."* **60.7%** said telephone, **57.1%** said text, with email at 14.3%. When asked in 2016/17, "*By which method would you prefer to contact your Diabetes Specialist Nurse", "by telephone"* had increased to **88.8%** and e-mail to **22.2%.** The increase in attendees wanting to contact the DSN by telephone causes issues out of hours. The percentage of accessing advice by email may have increased due the ease of access with improved mobile technology. This option perhaps could be used for OOH if there were a designated address and knowledge and that it was reviewed on a regular basis.

Another action from 2013 was to identify where and how attendees would prefer to get information about diabetes. **44.4%** (4) preferred verbal information, **33.3%** (3) preferred it to be available in clinic e.g. leaflets; **22.2%** (2) preferred a "*one to one with a health professional*" and "*On-line*" respectively. **22.2%** (2) were unsure. Even though numbers are small there is a variation as to the preferred method to obtain information.

When asked *"Which of the topics below would be of interest to you in relation to managing your diabetes?"* Some options returned similar percentages, where others returned contradicting percentages; e.g. 2013, *"Insulin treatment/delivery options":* **71.4%** compared with **44.4%** in 2017. The most evenly matched responses were "*What's new in diabetes"* and *"Stress Management."* For an additional question in 2016/17, **22.2%** (2) would like information about "Starting Work".

It is interesting to note that Stress Management recorded high percentages for both audits. This obviously is an area of importance to Young Adults and in particular for those with Diabetes. Perhaps further discussion is required as to how to best manage this, within the current resources available.

SECTION 2: Responses completed before leaving the clinic

Attendees were asked: "*Who would you like to see routinely at the Diabetes Clinic?"* for both audits. In 2013, additional health professionals were listed, but the 2016/17 re-audit focused on the Diabetes Doctor, Diabetes Specialist Nurse and the Dietitian. **71.4%** of attendees in 2013 highlighted they also wished to see the Clinic Nurse for height and weight and as this is part of the routine clinic process was not included. Podiatry and Exercise Counsellors are no longer part of the clinic.

For both audits the majority of attendees would routinely like to see the Diabetes Doctor and Diabetes Specialist Nurse. Consultations with the Dietitian, for both audits, were in the majority on a "*when needed basis"*. Interestingly no attendees said that they consulted with the Dietitian at clinics during the 2016/7 audit. Further discussions would be beneficial within the Clinic Team to ensure that attendees understand the importance of regular consultations with all health professionals within the team and perhaps guidance could be included in any contact leaflet developed.

The 2013 audit asked attendees to identify qualities they value from health professionals in the clinic. These qualities were evaluated in the 2016/17 audit and included being "*Knowledgeable*" "*Easy to talk to*" " *Listened to*" " *Setting of goals for care of you diabetes*". All the above qualities were evident in all staff, in the 2016/17 clinics. However, "*Open and Honest*", " *Respectful of your ideas*", " *Respectful of Lifestyle*", " *Supportive*", " *Not critical*" and " *Treated as an individual* were lower, between **87.5 - 75.0%**, as not all staff showed these qualities or the attendees were unsure. This requires further discussion with clinic team members".

Even with the low response rate, **66.6%** (85.7% - 2013) of attendees still felt that short waiting times were either "Very Important" or "Important", along with **77.7%** (92.9% - 2013) wanting to see the same doctor at each visit. It is perceived that the waiting times are better, and is perhaps dependent on how many clinic staff they see. Which doctor they see will depend on the frequency of attendance and whether they had previously seen a Consultant or a Registrar.

CONCLUSION

The actions identified within the improvement plan for 2013, in particular joint working on transition, had taken place. The DSN considers that waiting times have reduced and appear to have improved patient experience. Further discussions and actions are required for areas, such as Dietetic education sessions, contact details and in particular OOH access and procedures. In addition stress management and advice will be addressed by the Elgin Team. It is not proposed to re-audit for a while, as there have been DSN staffing change and it is felt appropriate to allow things to settle and implement the actions from the improvement plan before further service evaluation is undertaken.

IMPROVEMENT PLAN

- Develop a combined contact details leaflet, containing relevant number for each health professional team and in addition provide a reminder of who and how to contact for 'Out of Hours' advice - October 2017 - Sandra Wilson YP DSN
- Consider additional information in the leaflet on the transition process, importance of attendances and regular reviews with each clinic health professional, with possible development of a clinic passport – November 2017 – Sandra Wilson YP DSN
- YP DSN and the Elgin Clinic Dietitian to discuss the audit results and attendees access to dietetic advice – November 2017 – Sandra Wilson YP DSN
- How to assist "Young Adult" attendees to manage stress, within the current resources available, should be discussed within the clinical team - October 2017 - Sandra Wilson YP DSN
- The number of 'non-attendees' (DNAs) at the clinicneeds investigating. Attendees are asked to get bloods done prior to clinic, following which they book a diabetes clinic appointment. The reasons as to why they do not attend is not known – Work with Clinical Effectiveness to establish reasons - January 2018

ACKNOWLEDGEMENTS

- Thanks goes to all those involved in handing out the questionnaires
- Many thanks to all the Young People who completed the questionnaire
- Thanks to the Clinical Effectiveness Team for their continued support and advice

APPENDICES

- Appendix 1 Questionnaire

Elgin - Young Person's Diabetes Services Satisfaction Questionnaire

NHS Grampian

We are again reviewing the Young Person's Diabetes Service to identify if areas have improved since the last audit. We would be grateful if you could take a few minutes to fill in this questionnaire about your experiences about your transfer from the Children's Service and your experiences in the clinic.

Answer Section 1 whilst waiting to be seen and ***Section 2*** when you have finished. Please place your completed questionnaire in the "Internal" envelope provided or if you prefer to complete it at home, and post it back using a "Reply Paid" envelope also available. Your comments will be very helpful, all replies are anonymous and you cannot be identified from this questionnaire.

Many Thanks. Diabetes Specialist Nurses Team

Section 1

Q1 **How old are you?**

☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21+

Q2 **Are you....?** Male ..... ☐ Female .. ☐

Q3 **Are you....?**

☐ Still at School ☐ At University/College

☐ In Full-Time employment ☐ In Part-Time employment

☐ Not currently working

Q4 **Do you live....?**

☐ with your parents/carer ☐ with spouse/partner

☐ with friends/roommate ☐ alone

☐ live with other

If 'live with other' please specify:

Q5 **At what age were you first diagnosed with diabetes?**

Q6 **Which hospital were you attending when you were diagnosed with diabetes?**

☐ Royal Aberdeen Children's Hospital ☐ Aberdeen Royal Infirmary

☐ Dr Gray's Hospital ☐ Other Hospital

If Other please specify:

Q7a **How long have you been attending the Young Person's Diabetes Service Clinic...?**

☐ Less than 3 years (Go to 7b)

☐ More than 3 years (Go to 8a)

Q7b **Prior to attending the Young Person's Clinic which Hospital were you attending for the management of your diabetes?**

☐ Royal Aberdeen Children's ☐ Dr Gray's ☐ Other Hospital

If 'Other hospital' please state:

Prepared by NHSG Clinical Effectiveness Team October 2016 Page:1 ProjID 3485 Elgin

Q7c **If you transferred from the Childrens' service within the last 3 years, please comments on the process e.g. your understanding, explanation, smoothness etc...?**
If you did not come via this Children's Service , please write "Not applicable".

Q7d **Indicate which of the following took place pre-transfer?** *(Tick all that apply)*

- ☐ A chat with your hospital doctor to discuss any concerns you had about transfer
- ☐ Informal visit to see new clinic and meet staff
- ☐ Joint meeting with new and previous staff
- ☐ Written information on new service and contacts prior to transfer
- ☐ Group education/planning session prior to transfer

Q8a **Have you received contact information from the clinic team members:**

	Yes	*No*	*Not Sure*
Diabetes Specialist Nurses	☐	☐	☐
Doctor/Consultant	☐	☐	☐
Dietitian	☐	☐	☐

Q8b **When did you receive contact information from team members?** (Tick all that apply)

- ☐ Before leaving the Children's clinic
- ☐ At your first Young Person's Clinic
- ☐ Have not received information yet
- ☐ At another time
- ☐ Can't remember exactly

Please comment

Young Person's Service

Q9a **Which clinic(s) do you currently attend?** (Tick all that apply)

- ☐ Young Person's Clinic (David Anderson Building) Dr's: Gold, Mayo and Others
- ☐ Dr Gray's Hospital (Dr Strachan)
- ☐ Dr Gray's Hospital (Dr Park)
- ☐ Young Person's Clinic in Elgin (Dr Strachan)
- ☐ Fraserburgh (Dr Watson)
- ☐ Diabetes Nurse Led clinic
- ☐ Don't know

Q9b **How often do you attend the clinic(s) identified above: e.g. *Diabetes Nurse clinic every 3 months, Dr clinic every 6 months.* Please also state when last attended.**

Q9c **Who did you see at your 'last' Diabetes Clinic appointment** Tick all that apply

☐ Consultant ☐ Dietitian

☐ Diabetes Nurse ☐ Can't Remember

Q9d **Since that last clinic appointment, have you seen/contacted any other health professionals in relation to your diabetes e.g. GP etc. *If so state "who you saw" and "why" you had to contact them.***

Q10 **How often do you see the Dietitian in the Diabetes Clinic?**

☐ At each clinic visit ☐ Whenever I want

☐ Only if I ask ☐ Never

'Out of Hours Support'

Q11 **If you need advice about your diabetes 'Out of Hours' who do you contact?**

☐ NHS 24 ☐ Diabetes Specialist Nurse (DSN)

☐ Ward ☐ Accident and Emergency

Q12a **If you have sought assistance, how easy was it to get advice?**

☐ Very Easy ☐ Easy ☐ Difficult

☐ Very Difficult ☐ Not applicable

Please comment

Q12b **Did the advice given solve your query?**

☐ Yes ☐ No ☐ Not sure ☐ Not applicable

Q13 **By which method(s) would you prefer to contact your Diabetes Specialist Nurse?**

☐ Text ☐ Telephone ☐ Email

Q14 **How would you prefer to get information about Diabetes?** *(Tick all that apply)*

☐ Verbally in the Diabetes Clinic ☐ Online

☐ Drop in Sessions ☐ 1 :1 with a Health Professional

☐ Leaflets in the Diabetes Clinic ☐ Not sure

☐ Other method

Other method "please state"

Q15 **Which of the topics below would you be of interest to you in relation to managing your Diabetes?** *(Tick all that apply)*

- ☐ What's new in Diabetes
- ☐ Contraception/Family planning
- ☐ Carbohydrate Counting
- ☐ Stress Management
- ☐ Going to College/University
- ☐ Other topic
- ☐ Insulin treatment/ delivery options
- ☐ Alcohol / Drugs
- ☐ Cooking
- ☐ Exercise/Sport
- ☐ Starting Work

Other topic of interest _____

Section 2: Complete this just before leave clinic.

Healthcare Professionals and Facilities

Q16 **Who would you like to see routinely at the Diabetes Clinic?** (Tick all that apply)

	Always	*When needed*
Diabetes Consultant/Doctor	☐	☐
Dietitian	☐	☐
Diabetes Specialist Nurse	☐	☐

Q17 **Who did you have a consultation with at the Diabetes Clinic today?**

☐ Diabetes Consultant/Doctor ☐ Diabetes Specialist Nurse

☐ Dietitian ☐ Other Health Professional

Q18 **Previous satisfaction questionnaires have identified the following qualities that attendees at the clinic value in health professionals; were they evident during your consultation(s) today? Please say how many of the staff ... were...**

	All staff	*Some staff*	*None of them*	*Not sure*
Open and honest	☐	☐	☐	☐
Knowledgeable	☐	☐	☐	☐
Easy to talk to	☐	☐	☐	☐
Respectful of your ideas	☐	☐	☐	☐
Respectful of your lifestyle	☐	☐	☐	☐
Supportive	☐	☐	☐	☐
Not critical	☐	☐	☐	☐
Listened to what you had to say	☐	☐	☐	☐
Treated you as an individual	☐	☐	☐	☐
Helped you set goals for care of your diabetes	☐	☐	☐	☐

Q19 **What do you consider to be important when attending the Diabetes Clinic?** *(Please rate by importance to you)*

	Very important	*Important*	*Not important*
Short waiting time before initially being seen	☐	☐	☐
Short wait between seeing each health professional	☐	☐	☐
See Diabetes Team without your parents (if desired)	☐	☐	☐
To see the same Doctor at each visit, where possible	☐	☐	☐

Q20 **If you have any comments or suggestions about the Diabetes Service for Young People, please add them below:**

Please place your completed questionnaire in the "Internal" envelope and place in the box provided or if you prefer to complete it at home, use a "Reply Paid" envelope (also available) and post it back. Thank you for helping us with this project.

DISTRIBUTION LIST

Electronic Version of Report distributed to:

- Quality, Governance and Risk Team Leaders: Brenda Lurie, Liz Tait, Fiona Mitchelhill
- Clinical Effectiveness Team
- Clinical Governance Coordinators/Facilitators: Janice Rollo, Ashleigh Allan ***Note: For cross sector circulation to groups/committees within own sectors***
- David Cooper, Corporate Communications, NHSG, d.cooper@nhs.net
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- Diabetes Clinic Team (Elgin) via Linda Caie linda.caie@nhs.net
- Alison Wilson Paediatric Diabetic Specialist Nurse, Dr Gray's alison.wilson@nhs.net

Electronic Version of Report published on the Document Management System of NHS Grampian intranet Keywords: Audit, Diabetes, Young People (Re-Audit of Elgin Young Person's Diabetes Clinic – User Satisfaction)

Report also available from the Quality, Governance & Risk Unit webpage and listed under 'Most Recently Added' within the 'Clinical Audits Completed' folder Project ID: 3485

Physiotherapy Telephone Assessment User and Staff Experience Audit: Westhill and Peterhead Departments: May – July 2016

Report Published: October 2017

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INTRODUCTION

The Scottish Government's National Delivery Plan for Allied Health Professionals (AHP) is that from the 1st April 2016, the maximum waiting time for AHP Musculoskeletal (MSK) Services from referral to initial out-patient appointment should be 4 week for 90% of patients; by telephone, video consultation or face to face. To meet the Local Delivery Plan for the National AHP MSK Service's 4 week target, telephone assessments were considered by Aberdeenshire Health and Social Care Partnership as a way of achieving this objective.

AIM: To improve waiting times for Outpatient Physiotherapy in NHS Grampian

OBJECTIVES:

10. Reduce patient waiting times for Physiotherapy
11. Improve overall patient satisfaction in Physiotherapy
12. Increase cost effectiveness
13. Obtain feedback from Physiotherapists carrying out the telephone assessments

METHOD

Senior Physiotherapy staff were selected from two areas of Aberdeenshire with the longest waiting lists. Patients meeting certain inclusion/exclusion criteria (Appendix 1), from the referral information, were selected for this 3 month pilot (May to July 2016). Patients who met the criteria were sent a letter asking them to contact the Physiotherapy Department, to arrange a convenient time to carry out the assessment. Prior to the consultation, each Physiotherapist had a pre-printed assessment form. These contributed to the structuring of the assessment process, in a manner similar to a face to face consultation.

During the telephone consultation assessment, Physiotherapists offered advice, and where appropriate, sent self-management exercises by post. Patients were involved in decision making during the assessment, with outcome options comprising of face to face follow-up, an open review or discharge in order to self manage. Post assessment the patients were asked if they would consent to participating in completing a postal questionnaire, sent out if appropriate 6 to12 weeks after the consultation (Appendix 2).

This questionnaire was developed with the assistance of the Clinical Effectiveness Team building on previous user satisfaction audits and additional information about the new referral process. Ten questionnaires were distributed as a pilot, to gauge initial patient feedback. Thereafter, 128 questionnaires were posted from a total of 137 patients; nine potential respondents did not answer the telephone at the designated time.

In addition a physiotherapy staff feedback questionnaire was developed to obtain their thoughts as to what they liked and disliked about the process and any improvements in this pilot process.

RESULTS (n = 137 patients)

Telephone call statistics/outcomes

14. **4** Physiotherapists telephoned **137** patients during a 3 month period (May to July 2016)

Of those called at the specified time, **6.6% (9**) did not answer

16. **30.7% (42)** following the telephone consultation were asked to attend the Physiotherapy Department for a face to face appointment

17. **62.8% (86)** had a telephone consultation and were given contact details in order to arrange an appointment if there had been no progress within a 6 week period following self management advice. Appointments of this type are referred to as open appointments

Of the **62.8% (86)** who had an open appointment:

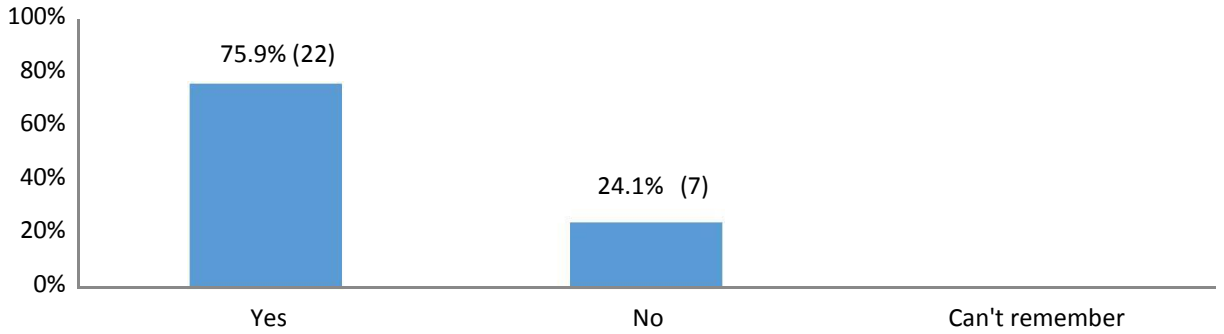
6. **18.6% (16)** took up the option to be seen again at the Physiotherapy Department for a face to face appointment

7. **81.4% (70)** did not require further treatment after 6 weeks and were then discharged

User Experience Questionnaire Feedback (n=29)

Consent was obtained from patients at the time of the initial telephone conversation to seek their agreement in order to send out questionnaires several weeks after the consultation. This was established to obtain patient feedback on the telephone consultation experience and record their levels of progress and outcomes. 128 patients gave consent and were posted a feedback questionnaire. **29** of the **128** returned a questionnaire giving a response rate of **22.7%**.

Q1: Before the consultation had you any previous experience of being treated with physiotherapy? (n=29)



Q2: Having agreed to the physiotherapy telephone consultation, please describe briefly your thoughts about the process, before it took place (25 comments)

8. Could not understand how Physiotherapist could fully assess my problem without physical contact
9. Did not think would be properly assessed through a phone conversation
10. Didn't agree. Was never asked. When phoned to query appointment was told this was what I was getting
11. Doubted that a phone consultation would offer a proper diagnosis
12. Easy and straight forward
13. Frustrated, hard to explain problem without them seeing you
14. Had no thoughts about the process
15. Happy enough. Saves both time
16. I did not realise before contacting the Physiotherapy Department that telephone consultations were available. I thought it was a good idea but was not sure how effective it would be
17. I don't think it is a good way of assessing if you need Physiotherapist as you can see the client and the client may not give you all the info.
18. I had to do the phone call during work time. I work in a reception and it was difficult to find peace to talk. I was a bit stressed

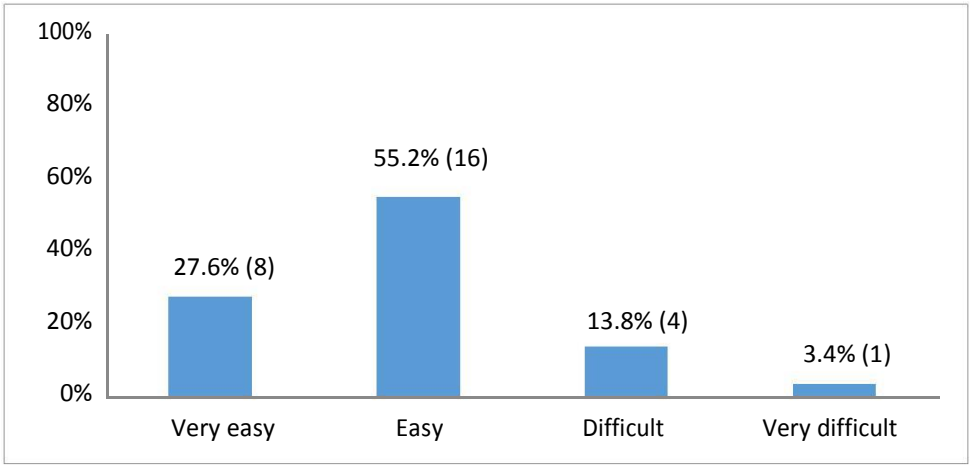
Q2: (continued)

2 I never agreed to a phone consultation. Found the process very poor and of no use
3 I thought it would be useful but for most problems the Physiotherapist should see the patient
4 I was hoping to ease the pain in my injury
5 I wasn't sure whether a phone consult would make sense as my specific problem required a physical examination. I expected the phone consult to be a short screening
6 I wasn't very sure as it was something new. I think it is better being shown exercises first
7 It made sense to assess the situation over the phone which in some cases could potentially free up more appointments if a patient could effectively treat themselves at home
8 Not aware there was a 'process'. Preference for 'face to face' contact
9 Slightly apprehensive as don't enjoy formal phone calls or medical appointments
10 Straight forward questions
11 The Peterhead element was fine. The preceding process i.e. nationally, saw me involved in 3 separate process which I thought were not the best use of resources i.e. less time consuming to just give me an appointment
12 Thought it was a good idea
13 Thought this was normal process for this service. Made it more personal
14 Was a bit worried with Physiotherapist not seeing when I experienced pain

Q3: Please indicate how long it was from the time you were referred to when you had your telephone consultation (n=29)

	Number	%
Less than 7 days	2	6.9%
1 to 2 weeks	11	37.9%
3 to 4 weeks	7	24.1%
5+ weeks	0	0.0%
Can't remember	9	31.0%

Q4: How easy did you find describing your symptoms over the telephone? (n=29)



Q4: (continued)
If 'Very Difficult' or 'Difficult', please explain (n=5):

10. Wanted to point to pain areas, not easy to explain over phone as felt I had to be specific about area but don't know what areas called
11. Difficult to describe physical pain adequately. Did not convey extent of incapacity
12. It was so difficult to explain the pain and feeling in my leg
13. Suffering severe pain and just told them
14. I found out that I was not telling the Physiotherapist everything

Q5: What was the outcome of the consultation? The Physiotherapist.... (n=29) [Some patients provided more than one response]

	Number	%
…assessed me and provided me with advice	12	41.4%
…emailed me treatment/exercise sheets	5	17.2%
…agreed to send me exercise sheets through the post	11	37.9%
…assessed me and advised a face to face consultatio n	13	44.8%
…advised me to contact the Department if I had any concerns/questions	6	20.7%
...advised I could phone physio. Department over the next 6 weeks for an open appointment if things did not improve	13	44.8%
...other outcome	5	17.2%

Other Outcomes:

2. Advised to go back to GP and be referred to orthopaedics
3. Get physiotherapy for shoulder
4. Saw Physiotherapist and was given exercises and bands
3. Sent equipment in post for completing exercises
4. The exercises given by post seem to be for the lower back area not the rib/dorsal area which still give me problems

Q6: If the Physiotherapist advised exercises, did you start them straight away? (n=29)

	Number	%
Yes	21	72.4%
No	1	3.4%
Not applicable	7	24.1%
Missing data	0	0.0%

Q7: If you were provided with exercise sheets by email or by post, did you understand the descriptions/pictures, explaining/showing how to carry out the exercises? (n=29)

	Number	%
Yes	17	58.6%
No	2	6.9%
Not applicable	9	31.0%
Missing data	1	3.4%

Q7: (continued) (n=2)

If No, please specify reason: Waited nearly 2 weeks to receive exercises and had to phone up again

Not applicable comment: Have already been in an exercise regime from previous

No Response comment:

ιϖ) Exercises didn't specify if had to be done daily

Q8: Did you manage to do the exercise(s)? (n=29)

	Number	%
Yes, all of them	21	72.4%
Some of them	2	6.9%
No, none of them	0	0.0%
Not applicable	6	20.7%
Missing data	0	0.0%

Comments from "Some of them" or "None of them **"** **:**

4. Pain too extreme on one of the exercises
5. Some made no sense and 1 was too painful

Comments from "Yes all of them" :

5. Some not at the beginning, but I worked at it

Q9a: After the consultation did you need to contact the Physiotherapy Department for additional advice? (n=29)

	Number	%
Yes	12	41.4%
No	17	58.6%
Missing data	0	0.0%

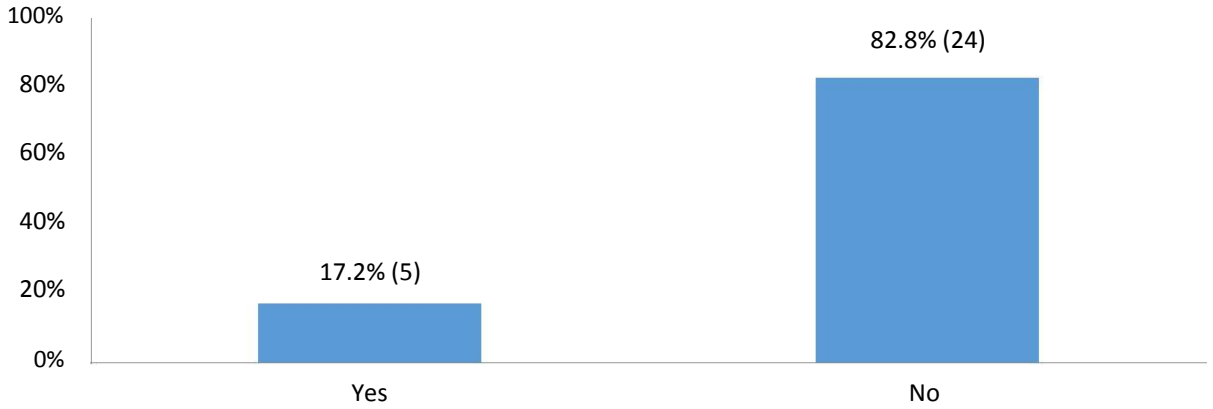
Comments:

- But didn't get it! Phoned for extension period but no answer and no call back

6. Did not think the exercises were working and was still in pain
7. Face to Face arranged

- Had ultrasound therapy
- Harder exercises
- I knew that I required physical examination
- I still can't go down stairs
- No change to condition. Required Face to Face consultation
- Ongoing issues with my knee
- The problem still persists
- Was not making much improvement re injury
- Was seen on a few occasions

Q9b: Following the consultation did you require to contact any other health professional for advice? (n=29)



Q10: What did you like about the consultation experience? (22 comments)

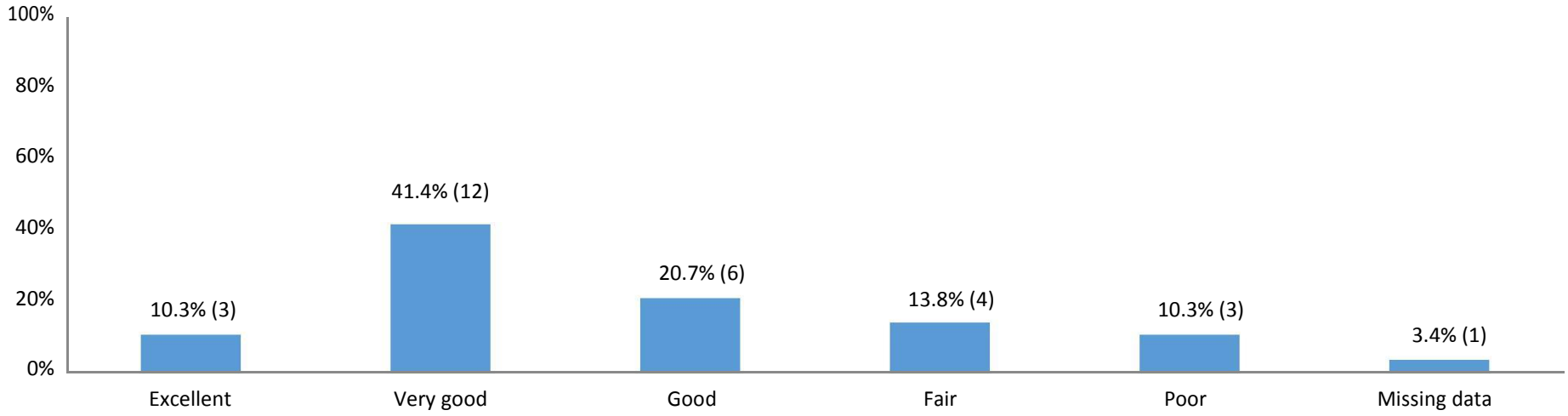
(ε) Done in comfort of own environment
(ϕ) Easy to speak to
(γ) Fairly straightforward apart from getting clarification
(η) Got proper exercises, as it turned out the exercise sheets I was given were the wrong type of exercise
(ι) Got things moving quickly
(φ) I had met and knew the person who phoned so I liked that
(κ) I would not like the phone experience again
(λ) It took a month for the Physiotherapist to get in touch after seeing the doctor and all I had was Paracetamol and pain gel
(μ) It was OK
(ν) Just the professionalism really
(ο) Less time consuming that visiting a practice for appointment and was able to get appointment much faster
(π) Little
(θ) Orthopaedics
(ϕ) Quick and understood my problem
(γ) Quicker and very nice lady that I had. Made me at ease
(η) The ****** spoke to was very pleasant, obviously knew h** job well and gave good advice
(ι) The Physiotherapist was very helpful
(φ) The time taken to do a thorough consultation and get a good overview about the complaints. The attitude you were listening with and time you gave me to explain
(κ) Valuable advice and the opportunity to discuss in detail the issues I was encountering
(λ) Very good telephone manner. Helpful. Reduced delay in starting exercises. Communication clear and timely, didn't feel forgotten
(μ) Very pleasant Physiotherapist
(ν) Was straightforward

Q11: What did you not like about the consultation experience? (17 comments)

(ι) Did not believe therapist engaged with specific circumstances
(φ) Face to face is preferable
(κ) I found it impersonal, unpleasant, no confidence that the exercises helped
(λ) I prefer face to face
(μ) Impersonal and detached
(ν) It was ok
(ο) It would be better face to face
(π) My work not thinking this was an appointment. Or the not getting the peace to do it. It was probably a combination of both. I can't remember being given a choice of appointments. I just took what I was told.
(θ) Needs to be done quicker
(ρ) Not 100% sure I did the exercises. Failed on 2 occasions to respond to follow up emails I sent

7. Not being face to face, but worked fine for nature of issue. Might not be suitable for more severe issue
8. Only thing I disliked, was it lacked the personal one to one which, sadly, is happening in many areas of the health profession. It could have been a very impersonal consultation had I not known the Physiotherapist.
9. Only thing I missed was 'face to face' initial assessment. However after the consultation by telephone I was much happier with the process
10. The pre-Peterhead / National element
11. Trying to explain without face to face contact
12. Wasting your time while knowing that I needed to see someone in person to examine my *******. Instead of speeding up the process by adding a phone consult I would rather have spent those 30 minutes face to face
13. Would have preferred a Face 2 Face from the start

Q12: How would you rate the telephone consultation process? (n=29)



Q13: Please feel free to make additional comments: (13 comments)

(Δ) Although this was my first experience of the telephone consultation system, I was pleased with the process. I felt that I could contact the Physiotherapy Department, if I felt I needed to. Overall I would be happy to use the telephone consultation system again

(Ε) Conversation provided very limited progress. Exercise sheets were informative but provided only marginal improvement

(Φ) Very polite, patient and easy to understand/talk to, also listened well to issue and answered all questions

(Γ) I wasn't sure if I was doing the exercises properly. I think it is better if you are actually shown.

(Η) I would have preferred to see the physio sooner although all I have now is a nagging ache the exercises are helping to trim my waistline

(Ι) I'm still in agony!

(ϑ) In my specific case it felt like the phone consult slowed things down

(3) If I had come into the practice for the 30 minutes that we spent on the phone i would have been seen earlier and you wouldn't have needed to make an additional appointment with me

(4) It was all I needed in a first stage. I felt well informed about me and I do believe it has helped me greatly. I have found it difficult to get back in touch with the problems I still have. I must get in touch for more help.

(5) It was ok but would be better face to face so that they could work your limit to see for themselves when you experienced pain

(6) H** was very nice and understanding

(7) No other comments except that the personal approach is not there and is obviously lacking.

(8) Was told by Physiotherapist at the consultation that the exercise sheet would not help me at all therefore 4-6 weeks of exercising were wasted

<u>Staff Questionnaire Responses</u> (n=3) 3 out of the 4 participating Physiotherapists responded; a 75.0% response rate.

Have you had previous experience of telephone physiotherapy assessments?

3 No
4 No
5 Yes

Do you feel you had the necessary skills and training to undertake a telephone assessment?

9 No. A little practical training prior to undertaking my first telephone assessment would have been beneficial.
10 No, not initially but it was quite straight forward once started.
11 Yes. I had previously offered physiotherapy advice over the phone and felt confident to do so.

What did you like about the telephone service?

16 It acts as a good triage tool to eliminate those patients who are either not suitable for physiotherapy or those who maybe don't really want treatment or aren't willing to work with the Physiotherapist.
17 It allowed patients to have contact with a Physiotherapist sooner.
18 Having the choice of discharge, open appointment or to book a face to face in the department allowed for accurate treatment planning. With experience it was found the majority of patients were suitable for open appointments with advice and this obviously had a beneficial impact on waiting lists. The tendency to "over treat" was eliminated.
19 Having the choice of 'open appointment' allowed you to place the responsibility into the patient's hands. This truly showed which patients really needed treatment.
20 Being able to offer advice over the phone, post out exercises and save the patient having to come into the department**.** Also that the slots were 20 minutes meaning that you were able to speak to more new patients over the phone than you would have been able to if they had an appointment in the department
21 I was able to give early advice to patients, and feedback from indicated they were given reassurance by this.

What did you not like about the telephone service?

9. Lack of initial training.
10. 20 minutes was very rushed for more complex patients.
11. Generally didn't seem to work for more elderly patients.
12. Not being able to do a follow up objective assessment with the patient and see their symptoms
13. Not knowing whether patients got better with my advice or went somewhere else for face to face Physiotherapy.
14. Not all patients were always appropriate. I had referrals for PGP and bursitis which I felt needed an initial face to face appointment and not telephone appointment.

Do you have any additional comments about the service?

16. I feel telephone assessments did work but equally wouldn't want to be doing it full time!
17. Although I didn't feel confident undertaking the telephone assessment initially it didn't take long until I felt my assessments were accurate and I was making the right choices in terms of the patients treatment planning – just took a little experience!
18. With the correct exclusion and inclusion criteria this service would probably work for most MSK settings.
19. Overall I think the telephone service was good and beneficial for many patients who did not need to opt into the service after advice and having an exercise programme sent out to them.
20. Certain conditions are going to require a face to face appointment but that doesn't mean that an initial telephone assessment is inappropriate.

DISCUSSION

This pilot study which was conducted over a 3 month period (May – July 2016) in Westhill and Peterhead, produced a number of encouraging outcomes. The response rate of 22.7% was disappointing, especially as it was a new service. It is not clear why the responses were so low. It is acknowledged that postal questionnaires can produce low responses. Previous physiotherapy user experience audits have had lower than expected response rates.

However, **51.7%** (15) of respondents indicated that the service was either 'Excellent' or 'Very Good', with a further **20.7%** (6) stating it was 'Good' (Question 12). These positive responses suggest that this project is worthy of further exploration. Considering the speculative nature of this project, it was perhaps surprising that only **10.3%** (3) of people thought that it represented a 'Poor' service.

75.9% (22) of respondents had received physiotherapy previously and were familiar with the context of physiotherapy sessions before participating in the telephone consultation (Question 1). Prior to commencement of the study respondents indicated a wide variety of opinions towards the concept of telephone consultation (Question 2), raising concerns as to how effective the delivery of a physiotherapy diagnosis and relevant treatment could be via a telephone consultation. Positive comments included "Happy enough saves both time", "made sense to assess the situation over the phone", "a patient could effectively treat themselves at home." "I thought it would be useful but for most problems the physiotherapist should see the patient." Negative comments included concerns "Did not think would be properly assessed through a phone conversation", "I never agreed to a phone consultation. Found the process very poor and of not use." "Doubted that a phone consultation would offer a proper diagnosis."

Positive comments post consultation included "it was easy and straight-forward". One person felt that it was "hard to explain the problem over the phone" while another "doubted that a phone consultation would offer a proper diagnosis." Significantly, after starting the process, **82.8%** (24) of respondents found it "Easy" or "Very Easy" to de scribe their symptoms over the phone (Question 4).

By employing a telephone service, patients were able to contact a Physiotherapist quicker than the current system. The waiting list for a physiotherapy appointment at the time of this study was four weeks. **44.8%** (13) of respondents were contacted in less than two weeks (Question 3). A major benefit of a telephone consultation within two weeks is that it allows the Physiotherapist to determine the most appropriate management strategy, which may identify a higher priority case for a face to face appointment.

One of the key challenges in managing a project of this type is to adequately prepare patients to become aware of what the process entails. Improving patient confidence that they will receive immediate advice and a suitable strategy for health improvement is a major factor in promoting the concept. It is important for staff involved in the project to be constantly aware that ongoing user satisfaction for both staff and patients is essential. This may be the case when recognising and identifying more complex patients. To ensure there is continuing user satisfaction, it is essential that all Physiotherapists are confident as to when to provide a face to face appointment. This will be largely attributable to the skill and professionalism of the individual practitioner. It may also depend on their training level and whether the Physiotherapist has had previous experience of telephone assessments.

Over the two sites, four Physiotherapists carried out telephone consultations and three Physiotherapists responded to the questionnaires. Previous experience varied between participating physiotherapists. One with no experience, felt at the beginning they did not have the necessary skills and that it would have been beneficial to have some training before commencing such an innovative practice. An important aspect of this study is the necessity to have high quality staff training in appropriate use of telephone skills.

Following the telephone consultation, **82.8%** (24) of respondents did not need to contact another health professional for advice (Question 9b), suggesting that they felt they were able to self manage with the advice given and the exercise sheets, where applicable. Less than half of respondents, **41.4%** (12) needed to contact the Physiotherapy Department after the telephone consultation (Question 9a). The reasons given for needing to contact the department were "ongoing issues" and "not making much improvement." Similar outcomes may have resulted from a face to face appointment and there is no indication that these outcomes are directly attributable to the telephone consultation itself.

From the patient feedback received, everyone that was prescribed exercises **72.4%** (21) were able to start them right away and only **6.9%** (2) of respondents did not understand what was required of them from their individualised exercise sheets (Questions 6 and 7). **72.4%** (21) managed to do all of the exercises that they were prescribed (Question 8).

While it is important to analyse the user experience from patient and staff feedback, it is also vital to consider the clinical perspective and allocation of time when employing this new study. If the sample of **137** patients were offered the usual 40 minute "New Patient" appointment, face to face within the department, it would have used **5,480** minutes of clinical time. In this pilot study, by offering each patient an initial 20 minute telephone appointment, only **2,740** minutes were used. Although **58** of the total sample went on to receive face to face appointments, **1580** minutes were saved by employing the telephone service, equivalent to **39** *New Patient appointments*. This means that an additional **39** new patients who required to be seen face to face, would be seen earlier than if the system was not in place.

CONCLUSION

This study set out to determine the feasibility of examining a cost effective means of improving waiting times for Outpatient Physiotherapy in NHS Grampian. Objectives of the study comprised reduced patient waiting times, improved overall patient satisfaction in Physiotherapy services and increased cost effectiveness. The study revealed that it is possible to successfully meet all three criteria with beneficial outcomes in each domain.

Reduced waiting times were evidenced by the significant number of patients who had their first physiotherapy contact within two weeks rather than the usual NHS Grampian waiting target time of four weeks. Consequently, a notable number of patients were assessed and treated earlier than would previously been the case.

Evidence of patient satisfaction was found in the recorded patient feedback where trends highlighted that, for a majority of respondents, it was relatively easy to describe symptoms on the phone. The ability of callers to describe their conditions effectively, allowed them to start exercises immediately. This practice is clearly of great benefit to patients as this early intervention can prevent symptoms from becoming more serious. This time saving strategy allows for a more streamlined service reducing the level of physiotherapy/patient contact in the majority of cases.

Where reservations were expressed from patient and staff feedback, these views can be addressed in future planning and review. These observations and comments could potentially strengthen this new framework as it continues to develop. Examples could include exploring age related appropriateness, management of more complex patients, and dealing with emerging new issues.

Another significant feature of the study relates to how enthusiastic staff are concerning the new project. An important aspect of findings in this area underpins the necessity to ensure that high quality staff training, in specialised telephone skills are made available as a key feature of successful implementation.
In summary, this study has proved highly relevant at this time in relation to the development of the Physiotherapy service in NHS Grampian. It shows that this specific new method of working is beneficial to patients and staff, and is highly cost effective. With a significant majority of patients finding that the new telephone consultation was excellent, very good or good, there is real scope to build and expand this concept as a viable and economical alternative to current practice in NHS Grampian.

IMPROVEMENT PLAN

Action	Month/Year by which action will be accomplished	Person responsible for overseeing action
Dissemination of results	September 2017	Clinical Effectiveness
Feedback findings to Physiotherapy Staff	September 2017	Muriel Nelson
Consider producing a poster to display audit findings in the Physiotherapy Department Reception Areas	October 2017	Muriel Nelson/ Sarah Norris
Re-audit – Snapshot	Summer 2018	Muriel Nelson/Clinical Effectiveness Team

ACKNOWLEDGEMENTS
Thank you to the patients who agreed to complete the questionnaire.
Thank you to the Physiotherapy Staff for handing out and getting the questionnaires back.

APPENDICES
Appendix 1 Inclusion/Exclusion criteria
Appendix 2 Patient Questionnaire
Appendix 3 Staff Questionnaire

APPENDIX 1 Telephone Assessment Consultation Exclusion/Inclusion Criteria

NHS Grampian Physiotherapy Telephone Assessment Service

Exclusion Criteria

2. Patients with hearing problems
3. Patients with vestibular problems
4. Patients for whom English is not their first language
5. Patients with learning disabilities
6. Under 16's
7. Recent surgical procedure – less than 12 weeks ago – and referred for that problem.
8. Urgent patients

Inclusion Criteria

(2) 16+
(3) Non urgent

APPENDIX 2 Patient Questionnaire

Physiotherapy Telephone Consultation Evaluation

NHS Grampian

Please take a few minutes to complete this questionnaire. We appreciate your feedback. Thank you in advance.

Before The Physiotherapy Telephone Consultation

Q1 **Before the consultation had you any previous experience of being treated with physiotherapy?**

☐ Yes ☐ No ☐ Can't Remember

Q2 **Having agreed to the Physiotherapy telephone consultation, please describe briefly your thoughts about the process, before it took place?**

Telephone Consultation

Q3 **Please indicate how long it was from: being referred to the telephone consultation.**

☐ Less than 7 days ☐ 1 to 2 weeks ☐ 3 to 4 weeks
☐ 5+ weeks ☐ Can't remember

Q4 **How "Easy" did you find describing your symptoms over the telephone?**

☐ Very Easy ☐ Easy ☐ Difficult ☐ Very Difficult

If 'Very Difficult' or 'Difficult' please explain why ..

Outcome of the Physiotherapy Telephone Consultation

Q5 **What was the outcome of the consultation?** (Tick all that apply)
The Physiotherapist.....

☐ ....assessed me and provided me with advice
☐ ....emailed me treatment/exercise sheets
☐ ....agreed to send me exercise sheets through the post
☐ ....assessed me and advised a face to face consultation
☐ ....advised me to contact the department if I had any concerns/questions
☐ ....advised me that I could phone the physiotherapy department over the next 6 weeks to get an "open" appointment, if things did not improve
☐ ....other outcome

'Other' outcome

Clinical Effectiveness Team October 2016 Project ID 3524

Self Management Advice Provided

Q6 If the Physiotherapist advised exercises, did you start them straight away?

☐ Yes ☐ No ☐ Not Applicable

If 'No' please specify reasons(s)

Q7 If you were provided with exercise sheets by email or by post, did you understand the descriptions/pictures, explaining/showing how to carry out the exercises?

☐ Yes ☐ No ☐ Not Applicable

If No, please specify reason(s)

Q8 Did you manage to do the exercise(s)?

☐ Yes, all of them ☐ No, none of them

☐ Some of them ☐ Not Applicable

If Some or None of them please explain

Q9a After the consultation did you need to contact the Physiotherapy Department for additional advice?

☐ Yes ☐ No

If 'Yes' please explain reason for contacting the Department.

Q9b Following the consultation did you require to contact any other health professional for advice?

☐ Yes ☐ No

Q10 What did you 'like' about the consultation experience?

Q11 What did you 'not like' about the consultation experience?

Q12 How would you rate the telephone consultation process?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Q13 Please feel free to make additional comments about your telephone consultation experience:

Thank you again for taking the time to complete this questionnaire. Please use the reply paid envelope provided to post it back.

Staff Questionnaire

8. **Have you had previous experience of telephone physiotherapy assessment?**

9. **Do you feel you had the necessary skills and training to undertake a telephone assessment?**

10. **What did you like about the telephone service?**

4. **What did you not like about the telephone service?**

5. **Do you have any additional comments about the service?**

DISTRIBUTION LIST

Electronic Version of Report distributed to:

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(4) Clinical Effectiveness Team

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Electronic Version of Report published on the Document Management System of NHS Grampian intranet Keywords: Audit (Physiotherapy, Telephone, Assessment, User Experience, Aberdeenshire) 2016

Report also available from the Quality, Governance & Risk Unit webpage and listed under 'Most Recently Added' within the 'Clinical Audits Completed' folder Project ID: 3524

Audit of Record Keeping ~School Nursing 2015/16

Published ~ October 2017 ~ Prepared by the Clinical Effectiveness Team

INTRODUCTION

Effective record keeping is an integral part of the nursing process and evidences the actions and decisions professionals have made. The need for auditing the standard of records is highlighted in the report of the *Haringey Area inspection of Baby P in 2008*[1] where one of the recommendations from the findings was to "establish rigorous procedures to audit and monitor the quality of case files across all partner agencies and ensure processes are in place to deliver improvement".

NHS Grampian (NHSG) have Children & Young People Community Nurses (C&YPCN) working in three different Sectors; Aberdeen City, Aberdeenshire and Moray. Children who have not yet started school have their nursing records held by a Health Visitor (HV), and School Nurses (SN) hold the records for those children who are attending school.

NHSG has a C&YPCN Records Group who regularly review the documentation (and guidance) in use to help ensure it meets the needs of its users and is in line with current legislation and other key drivers.

An audit of record keeping was completed in 2014 and this found examples of good practice and aspects of record keeping that could have been improved. Improvements were focussed towards addressing training needs through regular training events. In addition, one of the actions proposed for the 2014 audit was to review the audit tools and the process for collecting data for the next round of audit.

2. **AIM**: To assess the standard of record keeping in professionally held Community Child Records (CCR) and make improvements, where necessary.

Objectives:

3. To assess the current level of compliance in NHSG with the Nursing and Midwifery Council (NMC) Code[2]
4. For the records group to discuss and reach consensus in respect of what aspects of record keeping should be indicators of quality care and build the core dataset around this taking into account results from previous audits
5. To equip nursing teams with an audit pack which would facilitate continuous quality improvement using real time data

This is the overall NHSG audit report for Record Keeping; specifically records held by School Nurses at the time of the audit. A separate NHSG report will also be available reflecting the quality of records held by Health Visitors. In addition reports will be produced to reflect current practice for each Nursing sub-set (HV and SNs) at Sector level. By way of taking part in the audit, Teams within Sectors already have their individual results to review and action. Of note Family Nurse Practitioners (FNPs) are using the same audit pack to audit their records.

METHOD

The audit was designed in collaboration with School Nursing and Health Visitor representatives from each Sector, along with the Clinical Effectiveness Team. Guidance was developed on the back of these discussions to help ensure continuity regards data collection/input. The guidance also explains the sample selection and size.

The audit pack was piloted between September and December 2015. From this specific guidance was issued around case ascertainment so that records selected for audit were currently active i.e. the corresponding child was being seen by a School Nurse at the time of audit. Teams were asked to continue reviewing 2 sets of notes a month with the audit finishing in August 2016. Teams were then asked to submit their completed Microsoft™ Excel files to the Clinical Effectiveness Team for further collation and analysis.

Each Sector (Aberdeen City, Aberdeenshire and Moray) had a professional audit lead and they distributed audit packs to Teams.

Reviewers were supplied with an audit pack consisting of

4. A guidance document
5. Data collection form – Appendix 1
6. Excel spreadsheet

Table 1 below illustrates the case ascertainment

Table 1 – Number of records reviewed by type and Pr ofession holding notes at the time of the audit

Number of records reviewed by type of Profession		
Sector	**Community Child Record**	
	HV	**SN**
Aberdeen City	186	17
Aberdeenshire	128	110
Moray	90	68
Totals	**404**	**195**

RESULTS

Community Child Record

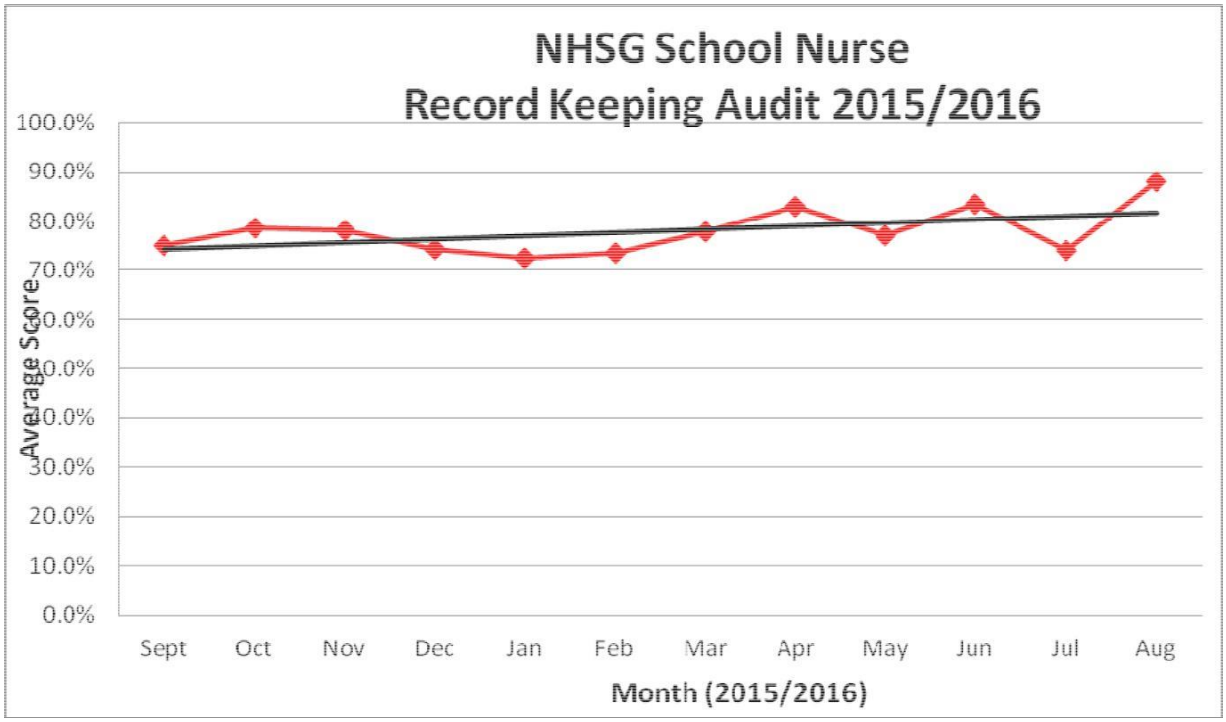
The Excel spreadsheet automatically generated a score for each of the **195** records audited, with the maximum possible score being 100%. **141** (72.3%) records achieved a score of 70% or more. The collated scores for the School Nurse record keeping for NHS Grampian are shown in Table 2 and Figure 1

Table 2 – Community Child Record ~ Scores achieved in NHS Grampian School Nursing Record Keeping

n=195

Community Child Record		2015/16
Under 50%	7	3.6%
50% to 59%	14	7.2%
60% to 69%	33	16.9%
70% to 79%	44	22.6%
80% to 89%	54	27.7%
90% to 99%	41	21.0%
100%	2	1.0%

Figure 1 Overall Scores Achieved – Monthly



Records were audited on several different criteria under different headings. The results for each individual criterion were recorded and are shown in Table 3. Percentage results for individual criteria have been categorised and illustrated as per the key shown below.

Key

Score achieved	Shading
<=50%	
51-69%	
>=70%	

Table 3 – Community Child Record ~ Scores achieved in NHS Grampian School Nursing Record Keeping

Identification Data	**Yes**	n=189
Child's Forename and Surname on EVERY sheet/booklet that has been used	84.6%	
Child's CHI Number (10 digits) on EVERY sheet/booklet that has been used	60.0%	
Child's address (incl Postcode) completed	88.2%	
Child's Sex	85.1%	
Primary Carers Name (check page 5 of record)	89.7%	
Primary Carers Contact Number (incl dialling code)	87.2%	
GP's practice	86.7%	
Parental rights and responsibilities (Mother)	41.0%	
Parental rights and responsibilities (Father)	31.3%	
Current Health Visitor/School Nurse name	59.0%	
Current Health Visitor/School Nurse contact details	50.3%	

Legibility	**Yes**	n=195
Are ALL entries legible?	97.4%	
Are ALL entries written in black ink?	92.8%	

Dates and signatures	**Yes**	n=195
Are ALL entries signed?	97.4%	
Are ALL entries dated?	95.9%	
Are ALL entries timed using the 24-hour (00:00) clock?	20.5%	
Does the clinical record include a means of identifying the signature and designation of the person making the entries?	58.5%	
Are entries made by pre registered nursing students countersigned by a registered nurse?	72.0%	n=25

Allergies	**Yes**	n=195
Is there evidence that the patient has been asked about allergies and/or previous reactions?	48.7%	

Enhancement of Accuracy	**Yes**	n=195
Is there written information for each contact?	95.4%	
Are ALL errors scored out with a single line?	81.3%	n=48
Are ALL errors initialled?	79.2%	n=49
Are ALL errors dated?	47.9%	n=47
Are ALL errors timed using the 24-hour clock?	18.8%	n=59
Are entries free from abbreviations? (NOTE : Except those in Appendix 37 of NHS Community Child Nursing Record Keeping guidelines 2015)	75.9%	
Is the record free from jargon/meaningless phrases?	97.9%	
Is the record free from speculation or opinion based statements?	98.5%	
Is the record free from blank spaces?	83.6%	
Are entries written in chronological order?	95.9%	
Is the chronology up to date and consistent with the content of the record?	75.4%	
Are all entries relevant and based on record keeping guidance?	90.8%	

Need identification Assessment and Care	Yes	n=195
Is there evidence that an assessment of need has been carried out?	84.1%	
Is there an individualised action plan for identified needs?	71.8%	
Is there evidence that the Child was involved in discussion regarding their needs/ action plan? (may not apply - see FAQs)	63.5%	n=126
Is there evidence that the parent/carer was involved in discussion regarding the child's needs/action plan? (may not apply - see FAQs)	81.4%	n=161
Is there evidence that the action plan has been updated when a new need arose?	71.8%	
Are action plans SMART (Specific, Measurable, Achievable, Realistic, Timely)?	71.8%	
In your professional opinion does the time lapse between review dates appear appropriate?	87.7%	
Is the information provided within the record easily understandable in communicating the child's needs to a professional who does not know the child?	82.6%	

FREETEXT COMMENTS

Out of the **195** records audited, **118** (60.5%) had comments recorded on the Excel sheet. Examples of comments from reviewers are categorised below and all comments are listed in Appendix 2.

Scope of audit

5. Content satisfactory. Discussed audit with staff
6. Discussed with team
7. Not all audit questions relevant to these older notes.

Observation of practice - good

6. Able to read
7. Additional information stored according to record keeping protocol
8. Clear, concise and relevant
9. Evidence of future planning. Older record.
10. Excellent record
11. Good considering high workload and lack of capacity
12. New to area. Only a few entries for child. All appropriate.

Negative comments:

(χ) CHI only recorded as last 4 digits
(δ) Child has moved practices on 3 occasions. Not followed up appropriately for a child of their potential needs.
(ε) Chronology does not record new to area.
(ϕ) Comments about the number of records received at one time from school nurse. Also no contact details of parents or who GP is
(γ) New to area. No birth details, minimal information in record
(η) No evidence of contact at 1 year. Old style records no chronology
(ι) No 1 year review. Seen at 38 weeks, then not until 27 month review. Notes very sparse.
(φ) No place to record child's sex and ???
(κ) No place to record sex. Child now on supervision order. Notes do not reflect this.
(λ) No written info at start of record (IT record). Chronology started school age
(μ) Not clear why additional only seen as per core programme. No evidence of plan being followed.
(ν) Old record before rights and responsibilities documented and 24 hr clock
(ο) The SN had no information on previous history as yet and school off. Information not available
(π) Original record from out with area. Partial details only in new record

DISCUSSION/CONCLUSION

The trend line in Figure 1 is indicative of a gradual upwards improvement in the standard of record keeping amongst School Nurses during the audit period. With the average audit score of records being 75.2**%** during the audit pilot period and records with an overall average score of 88.1% in the last month of the audit - a **12.9%** improvement.

Appendix 3 illustrates the scores achieved by individual criterion in ascending order.
The following have been identified as the highest scoring criteria.

Top five scoring criteria: (% of records complying)

(δ) Is the record free from speculation or opinion based statements? 98.5%
(ε) Is the record free from jargon/meaningless phrases? 97.9%
(ϕ) Are ALL entries signed? 97.4%
(γ) Are ALL entries legible? 97.4%
(η) Are entries written in chronological order? 95.9%

The following have been identified as the poorest scoring criteria. (% of records complying)

(ε) Are ALL errors dated? 47.9%
(ϕ) Parental rights and responsibilities (Mother) 41.0%
(γ) Parental rights and responsibilities (Father) 31.3%
(η) Are ALL entries timed using the 24-hour (00:00) clock? 20.5%
(ι) Are ALL errors timed using the 24-hour clock? 18.8%

Results for individual criteria have been categorised into traffic light colours to help illustrate which areas School Nurses are performing well in and where there are concerns. However the score for each criteria should be considered carefully. For example, is it acceptable for the Chronology not to be completed in nearly 25% of records?

Criteria asking whether there was evidence in the record of the child and their parent being involved in discussion regarding their needs/action plan scored highly indicating that the records are Person centred in respect of involvement. Further quality improvement activity should incorporate other elements of person centeredness such as:

(ϕ) Is there evidence of what information the child/carer needs to allow them to achieve their goals?
(γ) The level and amount of contact available/desired to/by the child/parent/family? and
(η) "What/who matters to them (the child and parent/family) to give them the best possible care?

Teams were tasked with reviewing their audit results on a monthly basis throughout the audit period and the audit pack allowed them to record their planned improvements so they could share with their Team and learn from this. Anecdotal feedback from staff auditing the records was mixed. Most staff feeding back found the process useful and the audit helped them identify issues and manage this within their Teams. Some Teams reported that due to changes in staffing and staff shortages/vacancies that they found it difficult to manage the audit and there was some misunderstanding around which cases were to be selected for audit.

There was discussion at the November 2016 C&YPCN Records Group meeting around the requirement for continuous audit of records so that standards don't slip in between audits and to provide assurance that we as an organisation can provide, and actively reflect on real time data which drives improvement. There has also been discussion around developing a qualitative peer review audit which could link in with the 'Reflective Discussion' element of the NMC Re-Validation.

It needs to be considered where and how professionals write down that a record has been audited with the date. Similarly, if there are any concerns with the quality of the record or the professional competence of staff completing a record – how is this managed?

Further quality improvement activity in respect of child records in the community should be mindful that the C&YPCN Records Group are working towards an electronic record and how audit or similar is built into this; Allied Health Professionals are doing a qualitative peer review audit which the Group could learn from and there is innovative work being progressed in patient records across NHS Grampian.

Finally, but arguably most importantly, the records should actively demonstrate that the child and those that are important to them are safe from harm, in that Public Protection concerns have been assessed, identified and managed appropriately. Various risk assessments are already in place such as GIRFEC and 'My World Triangle' and the chronology of the record identifies, records and actions significant events to facilitate this. Staff working with children and young people should have knowledge of the recently produced Public Protection e-cards available on the 'Public Protection' webpage on the NHSG intranet. Not limited, but potentially linked to Child Protection, these sign-post staff to what to do/who to refer to for any public protection concerns – e.g. Fire risk, Female Genital mutilation, Domestic abuse, Child Exploitation, Financial abuse and each card contains the strap line 'Recognise, Respond, Report, Record, Reflect'. In light of this the C&YPCN Records Group may also want to consider how Public Protection Concerns are recorded and subsequently audited within the record.

IMPROVEMENT PLAN

(g) Share results with C&YPCN Sector Leads and discuss next steps:
continued/ future audit
follow up from actions
SBAR report to be completed by all Sector Leads (Moray, Aberdeen City, Aberdeenshire)

(h) Recommendations from SBARs implemented, August 2017

ACKNOWLEDGEMENTS

All Nursing teams that took part in the audit process.
Tanya Johnston and Blair Watt, Clinical Effectiveness Team

REFERENCES/BIBLIOGRAPHY

(h) Ofsted., Healthcare Commission., HM Inspectorate of Constabulary. *Review of services for children and young people, with particular reference to safeguarding. (2008) ,* Available at: *https://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/haringey/022_Joint%20Area%20Review%20-%20Main%20report%20as%20pdf.pdf* (Accessed: 17th May 2017).

(i) Nursing And Midwifery Council (NMC), 2015. *The code: professional standards of practice and behaviour for nurses and midwives. London.* NMC

2.

APPENDICES

(i) Data collection form
(j) Full Freetext comments
(k) Criteria scores in ascending

DATA COLLECTION FORM **APPENDIX 1**

Q	Identification Data		Record 1	Record 2
1	Child's Forename and Surname on every sheet/booklet that has been used	y/n/p		
2	Child's CHI Number (10 digits) on every sheet/booklet that has been used	y/n/p		
3	Child's address (incl Postcode) completed	y/n/p		
4	Child's Sex	y/n		
5	Primary Carers Name (check page 5 of record)	y/n/p		
6	Primary Carers Contact Number (incl dialling code)	y/n/p		
7	GP's practice	y/n/p		
8	Parental rights and responsibilities (Mother)	y/n/p		
9	Parental rights and responsibilities (Father)	y/n/p		
10	Current Health Visitor/School Nurse name	y/n/p		
11	Current Health Visitor/School Nurse contact details	y/n/p		
	Legibility		**Record 1**	**Record 2**
12	Are ALL entries legible?	y/n/p		
13	Are ALL entries written in black ink?	y/n/p		
	Dates and signatures		**Record 1**	**Record 2**
14	Are ALL entries signed?	y/n/p		
15	Are ALL entries dated?	y/n/p		
16	Are ALL entries timed using the 24-hour (00:00) clock?	y/n/p		
17	Does the clinical record include a means of identifying the signature and designation of the person making the entries?	y/n/p		
18	Are entries made by pre registered nursing students countersigned by a registered nurse?	y/n/p/x		
	Allergies		**Record 1**	**Record 2**
19	Is there evidence that the child/parent has been asked about allergies and/or previous reactions?	y/n/p		
	Enhancement of Accuracy		**Record 1**	**Record 2**
20	Is there written information for each contact?	y/n		
21	Are ALL errors scored out with a single line?	y/n/p/x		
22	Are ALL errors initialled?	y/n/p/x		
23	Are ALL errors dated?	y/n/p/x		
24	Are ALL errors timed using the 24-hour clock?	y/n/p/x		
25	Are entries free from abbreviations? (NOTE : Except those in Appendix 37 of NHS Community Child Nursing Record Keeping guidelines 2015)	y/n		
26	Is the record free from jargon/meaningless phrases?	y/n		
27	Is the record free from speculation or opinion based statements?	y/n		
28	Is the record free from blank spaces?	y/n		
29	Are entries written in chronological order?	y/n		
30	Is the chronology up to date and consistent with the content of the record?	y/n		
31	Are all entries relevant and based on record keeping guidance?	y/n		
	Need identification Assessment and Care		**Record 1**	**Record 2**
32	Is there evidence that an assessment of need has been carried out?	y/n/p		
33	Is there an individualised action plan for identified needs?	y/n/p		
34	Is there evidence that the Child was involved in discussion regarding their needs/ action plan? (may not apply – FAQs)	y/n/p/x		
35	Is there evidence that the parent/carer was involved in discussion regarding the child's needs/action plan? (may not apply – see FAQs)	y/n/p/x		
36	Is there evidence that the action plan has been updated when a new need arose?	y/n/p		
37	Are action plans SMART (Specific Measurable Achievable Realistic Timely)?	y/n/p		

38	In your professional opinion does the time lapse between review dates appear appropriate?	y/n/p		
39	Is the information provided within the record easily understandable in communicating the child's needs to a professional who does not know the child?	y/n/p		

Comments Full Text **APPENDIX 3**

- Child new to area and notes audited on immunisation record basis only
- 24hr clock
- 24hr clock review of errors
- Able to read
- Additional information stored according to record keeping protocol
- Advised of audit agreed as a team any record written in.SN to ensure it meets standards
- Again new to area record. No information as child register at another practice. Core programme
- As before
- As before
- Based only on the SN input
- Chi only recorded as last 4 digits
- Child has moved practices on 3 occasions. Not followed up appropriately for a child of their potential needs.
- Child new to area and notes audited on immunisation record basis only
- Child new to area and notes audited on immunisation record basis only
- Chronology does not record new to area.
- City to shire record . As previous record but new S/N documenting according to guidelines.
- Clear, concise and relevant
- Comments about the number of records received at one time from school nurse. Also no contact details of parents or who GP is
- Content satisfactory. Discussed audit with staff
- Discussed with manager
- Discussed with team
- Evidence of future planning. Older record.
- Excellent record
- Excellent record
- Family recently immigrated and notes new with school nurse
- Good
- Good
- Good considering high workload and lack of capacity
- Good quality record. Evidence of assessment of need. No chronology - old record
- Good record
- Good record and a lot easier as new record
- Good record keeping easier as new notes
- Handover from HV not seen by S/N yet.
- Minimal information - school record only. No complex needs
- New style record
- New to area and country
- New to area record
- New to area. No birth details, minimal information in record
- New to area. Only a few entries for child. All appropriate.
- Newer record so improvement in record keeping.
- No 1 year review. Seen at 38 weeks, then not until 27 month review. Notes very sparse.
- No evidence of contact at 1 year. Old style records no chronology
- No place to record child's sex and Parental Rights and Responsibility
- No place to record child's sex and Parental Rights and Responsibility
- No place to record child's sex and Parental Rights and Responsibility

Comments Full Text **APPENDIX 3**

7. No place to record child's sex and Parental Rights and Responsibility
8. No place to record child's sex and Parental Rights and Responsibility
9. No place to record child's sex and Parental Rights and Responsibility
10. No place to record child's sex and Parental Rights and Responsibility
11. No place to record Parental Rights and Responsibility
12. No place to record sex and Parental Rights and Responsibility
13. No place to record sex and Parental Rights and Responsibility
14. No place to record sex. Child now on supervision order. Notes do not reflect this.
15. No written info at start of record (IT record). Chronology started school age
16. Not all audit questions relevant to these older notes.
17. Not all questions are relative for these older notes.
18. Not all questions relevant for these notes.
19. Not clear why additional only seen as per core programme. No evidence of plan being followed.
20. Notes form different area/authority
21. Old record
22. Old record
23. Old record
24. Old record
25. Old record
26. Old record and 24 hr clock
27. Old record before rights and responsibilities documented and 24 hr clock
28. Old record but filled in well
29. Old record used in last 6 months
30. Old record used in last 6 months
31. Old record, 24 hr clock
32. Old records harder to look at all info as appears less structured
33. Old style record
34. Old style record
35. Old style record
36. Old style record
37. Old style record
38. Old style record
39. Old style record
40. Old style record
41. Old style record
42. Old style record
43. Old style record
44. Old style record
45. Old style record
46. Old style record no area for PR&R
47. Old style record which does not contain info re parental rights
48. Old style record.
49. Old style records.
50. Older record
51. Older record information appropriate for age of record.
52. Older record so no area for R and R.
53. Older record so some info not available or space for it not available.

Comments Full Text **APPENDIX 3**

2. Older record, some questions not asked e.g. Sex of child.
3. Older records questions not all pertinent to the record format
4. Older records. No provision for recording some information being asked for in audit.
5. Ongoing themes
6. Original record from out with area. Partial details only in new record
7. Record commenced 2008 therefore not all questions applicable
8. Record from previous area. No action plan.
9. Record improving
10. Record incomplete, assessment not written in contact record
11. Records appropriate for age of record
12. Records commenced in 1999 therefore not all questions applicable Notes for P1
13. Routine core child. New to area
14. S1 record old style. As with other record.
15. Same as previous record
16. Secondary 1 record, old style. Recent recording in accordance with records keepnig guidelines, but older record keeping, eg 2007.
17. Similar, old record well completed.
18. The information that lets this record down came with the record
19. The SN had no information on previous history as yet and school off. Information not available
20. The SN had no information on previous history as yet and school off. Information not available
21. The SN had no information on previous history as yet and school off. Information not available
22. The SN had no information on previous history as yet and school off. Information not available
23. This is a HPI of Core. The record appeared well documented
24. This is an old record that has been active in the last 6 months,
25. This is the new style records asit was new pt to area prior to school entrty
26. Transfer from HV

Comments Full Text **APPENDIX 3**

	Yes	Partial	No	Missing	
Are ALL errors timed using the 24-hour clock?	18.8%	12.5%	91.7%	0.0%	n=59
Are ALL entries timed using the 24-hour (00:00) clock?	20.5%	26.2%	53.3%	0.0%	
Parental rights and responsibilities (Father)	31.3%	5.1%	63.6%	0.0%	
Parental rights and responsibilities (Mother)	41.0%	0.0%	59.0%	0.0%	
Are ALL errors dated?	47.9%	2.1%	47.9%	0.0%	n=47
Is there evidence that the patient has been asked about allergies and/or previous reactions?	48.7%	1.5%	49.2%	0.5%	
Current Health Visitor/School Nurse contact details	50.3%	1.5%	47.7%	0.5%	
Does the clinical record include a means of identifying the signature and designation of the person making the entries?	58.5%	10.8%	30.8%	0.0%	
Current Health Visitor/School Nurse name	59.0%	3.1%	37.9%	0.0%	
Child's CHI Number (10 digits) on EVERY sheet/booklet that has been used	60.0%	15.9%	22.6%	1.5%	
Is there evidence that the Child was involved in discussion regarding their needs/ action plan? (may not apply - see FAQs)	63.5%	0.0%	36.5%	0.0%	n=126
Is there an individualised action plan for identified needs?	71.8%	5.1%	23.1%	0.0%	
Is there evidence that the action plan has been updated when a new need arose?	71.8%	4.6%	23.1%	0.0%	
Are action plans SMART (Specific, Measurable, Achievable, Realistic, Timely)?	71.8%	7.2%	21.0%	0.0%	
Are entries made by pre registered nursing students countersigned by a registered nurse?	72.0%	4.0%	24.0%	0.0%	n=25
Is the chronology up to date and consistent with the content of the record?	75.4%		24.6%	0.0%	
Are entries free from abbreviations? (NOTE : Except those in Appendix 37 of NHS Community Child Nursing Record Keeping guidelines 2015)	75.9%		24.1%	0.0%	
Are ALL errors initialled?	79.2%	2.1%	20.8%	0.0%	n=49
Are ALL errors scored out with a single line?	81.3%	0.0%	18.8%	0.0%	n=48
Is there evidence that the parent/carer was involved in discussion regarding the child's needs/action plan? (may not apply - see FAQs)	81.4%	1.2%	17.4%	0.0%	n=161
Is the information provided within the record easily understandable in communicating the child's needs to a professional who does not know the child?	82.6%	3.6%	13.8%	0.0%	
Is the record free from blank spaces?	83.6%		16.4%	0.0%	

Comments Full Text

APPENDIX 3

Is there evidence that an assessment of need has been carried out?	84.1%	6.7%	9.2%	0.0%
Child's Forename and Surname on EVERY sheet/booklet that has been used	84.6%	6.2%	8.7%	0.0%
Child's Sex	85.1%	0.0%	14.9%	0.0%
GP's practice	86.7%	3.6%	9.7%	0.0%
Primary Carers Contact Number (incl dialling code)	87.2%	4.1%	8.2%	0.5%
In your professional opinion does the time lapse between review dates appear appropriate?	87.7%	1.5%	10.3%	0.0%
Child's address (incl Postcode) completed	88.2%	5.6%	6.2%	0.0%
Primary Carers Name (check page 5 of record)	89.7%	3.1%	7.2%	0.0%
Are all entries relevant and based on record keeping guidance?	90.8%		7.7%	1.5%
Are ALL entries written in black ink?	92.8%	0.5%	6.7%	0.0%
Is there written information for each contact?	95.4%		4.6%	0.0%
Are ALL entries dated?	95.9%	1.5%	2.6%	0.0%
Are entries written in chronological order?	95.9%		4.1%	0.0%
Are ALL entries legible?	97.4%	1.5%	1.0%	0.0%
Are ALL entries signed?	97.4%	0.5%	2.1%	0.0%
Is the record free from jargon/meaningless phrases?	97.9%		2.1%	0.0%
Is the record free from speculation or opinion based statements?	98.5%		1.5%	0.0%

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4. Clinical Effectiveness Team
5. Clinical Governance Coordinators/Facilitators: Janice Rollo, Ashleigh Allan
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10. Shelley Taylor, Child protection. Nurse Specialist
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Audit of Children and Young People Community Nursing Record Keeping in NHS Grampian Health Visitors 2015/16

Published ~ October 2017 ~ Prepared by the Clinical Effectiveness Team

INTRODUCTION

Effective record keeping is an integral part of the nursing process and evidences the actions and decisions professionals have made. The need for auditing the standard of records is highlighted in the report of the *Haringey Area inspection of Baby P in 2008* [1] where one of the recommendations from the findings was to "*establish rigorous procedures to audit and monitor the quality of case files across all partner agencies and ensure processes are in place to deliver improvement*".

NHS Grampian (NHSG) have Children & Young People Community Nurses (C&YPCN) working in three different Sectors; Aberdeen City, Aberdeenshire and Moray. Children who have not yet started school have their nursing records held by a Health Visitor (HV), and School Nurses (SN) hold the records for those children who are attending school.

NHS Grampian has a C&YPCN Records Group who regularly review the documentation (and guidance) in use to help ensure it meets the needs of its users and is in line with current legislation and other key drivers.

An audit of record keeping was completed in 2014 and this found examples of good practice and aspects of record keeping that could have been improved. Improvements were focussed towards addressing training needs through regular training events. In addition one of the actions proposed for the 2014 audit was to review the audit tools and the process for collecting data for the next round of audit.

4. **AIM**: To assess the standard of record keeping in professionally held Community Child Records (CCR) and make improvements, where necessary.

Objectives:

5. To assess the current level of compliance in NHSG with the Nursing and Midwifery Council (NMC) Code[2]
6. For the records group to discuss and reach consensus in respect of what aspects of record keeping should be indicators of quality care and build the core dataset the audit around this, taking into account results from previous audits
7. To equip nursing teams with an audit pack which would facilitate continuous quality improvement using real time data

This is the overall NHSG audit report for Record Keeping; specifically records held by Health Visitors at the time of the audit. A separate NHSG report will also be available reflecting the quality of records held by School Nurses. In addition reports will be produced to reflect current practice for each Nursing sub-set (HV and SNs) at Sector level. By way of taking part in the audit, Teams within Sectors already have their individual results to review and action. Of note, Family Nurse Practitioners (FNPs) are using the same audit pack to audit their records.

METHOD

The audit was designed in collaboration with School Nursing and Health Visitor representatives from each Sector, along with the Clinical Effectiveness Team. Guidance was developed on the back of these discussions to help ensure continuity regards data collection/input. The guidance also explained the sample selection and size.

The audit pack was piloted between September and December 2015. From this specific guidance was issued around case ascertainment so that records selected for audit were currently active i.e. the corresponding child was being seen by a Health Visitor at the time of audit. Teams were asked to continue reviewing 2 sets of notes a month with the audit finishing in August 2016. Teams were then asked to submit their completed Excel files to the Clinical Effectiveness Team for further collation and analysis.

Each Sector (Aberdeen City, Aberdeenshire and Moray) had a professional audit lead and they distributed audit packs to Teams.

Reviewers were supplied with an audit pack consisting of

6. A guidance document
7. Data collection form – Appendix 1
8. Excel spreadsheet

Table 1 below illustrates the case ascertainment

Table 1 – Number of records reviewed by Sector and Profession holding notes at the time of the audit

Number of records reviewed by type of Profession		
Sector	**Community Child Record**	
	HV	**SN**
Aberdeen City	186	17
Aberdeenshire	128	110
Moray	90	68
Totals	**404**	**195**

RESULTS

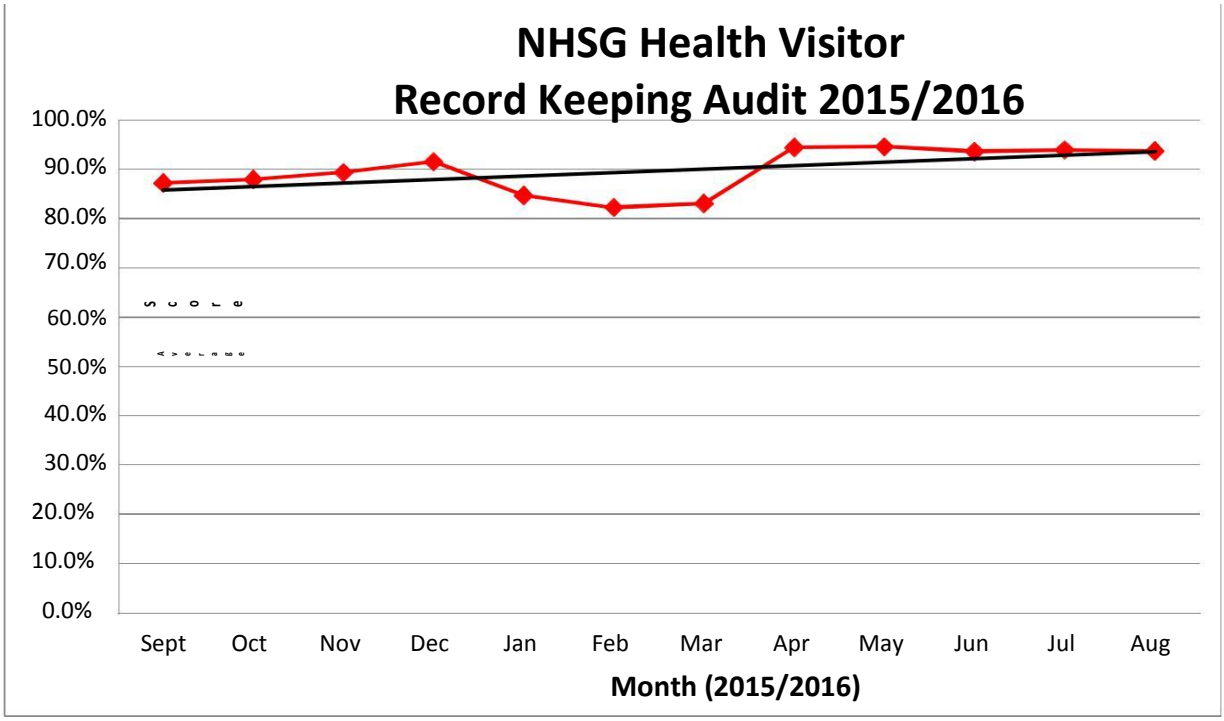
Community Child Record

The Excel spreadsheet automatically generated a score for each of the **404** records audited, with the maximum possible score being 100%. **396** (98.0%) records achieved a score of 70% or more. The collated scores for the Health Visitor record keeping for NHS Grampian are shown in Table 2 and Figure 1

Table 2 – Community Child Record ~ Scores achieved in NHS Grampian Health Visitors Record Keeping

		n=404
Community Child Record		**2015/16**
Under 50%	2	0.5%
50% to 59%	2	0.5%
60% to 69%	4	1.0%
70% to 79%	21	5.2%
80% to 89%	112	27.7%
90% to 99%	218	54.0%
100%	45	11.1%

Figure 1 Overall Scores Achieved – Monthly



Records were audited on several different criteria under different headings. The results for each individual criterion were recorded and are shown in Table 3 and are shown in ascending order of score achieved in Appendix 3.

Key:

Score achieved	Shading
<=50%	
51-69%	
>=70%	

Table 3 – Community Child Record ~ Scores achieved in NHS Grampian Health Visitor Record Keeping

Identification Data	Yes
Child's Forename and Surname on EVERY sheet/booklet that has been used	87.4%
Child's CHI Number (10 digits) on EVERY sheet/booklet that has been used	77.7%
Child's address (incl Postcode) completed	99.0%
Child's Sex	97.8%
Primary Carers Name (check page 5 of record)	97.8%
Primary Carers Contact Number (incl dialling code)	96.8%
GP's practice	97.0%
Parental rights and responsibilities (Mother)	93.8%
Parental rights and responsibilities (Father)	91.8%
Current Health Visitor/School Nurse name	90.8%
Current Health Visitor/School Nurse contact details	91.3%

Legibility	Yes
Are ALL entries legible?	94.6%
Are ALL entries written in black ink?	98.0%

Dates and signatures	Yes	
Are ALL entries signed?	99.3%	
Are ALL entries dated?	98.8%	
Are ALL entries timed using the 24-hour (00:00) clock?	43.6%	
Does the clinical record include a means of identifying the signature and designation of the person making the entries?	88.1%	
Are entries made by pre registered nursing students countersigned by a registered nurse?	91.8%	n=49

Allergies	Yes
Is there evidence that the patient has been asked about allergies and/or previous reactions?	53.0%

Enhancement of Accuracy	Yes	
Is there written information for each contact?	99.8%	
Are ALL errors scored out with a single line?	77.8%	n=108
Are ALL errors initialled?	74.1%	n=109
Are ALL errors dated?	42.6%	n=109
Are ALL errors timed using the 24-hour clock?	28.7%	n=121
Are entries free from abbreviations? (NOTE : Except those in Appendix 37 of NHS Community Child Nursing Record Keeping guidelines 2015)	84.9%	
Is the record free from jargon/meaningless phrases?	99.8%	
Is the record free from speculation or opinion based statements?	99.0%	
Is the record free from blank spaces?	76.2%	
Are entries written in chronological order?	97.8%	
Is the chronology up to date and consistent with the content of the record?	92.8%	
Are all entries relevant and based on record keeping guidance?	98.8%	

Need identification Assessment and Care	Yes	
Is there evidence that an assessment of need has been carried out?	95.3%	
Is there an individualised action plan for identified needs?	93.6%	
Is there evidence that the Child was involved in discussion regarding their needs/ action plan? (may not apply - see FAQs)	85.7%	n=35
Is there evidence that the parent/carer was involved in discussion regarding the child's needs/action plan? (may not apply - see FAQs)	94.4%	n=393
Is there evidence that the action plan has been updated when a new need arose?	93.3%	
Are action plans SMART (Specific, Measurable, Achievable, Realistic, Timely)?	89.1%	
In your professional opinion does the time lapse between review dates appear appropriate?	93.3%	
Is the information provided within the record easily understandable in communicating the child's needs to a professional who does not know the child?	96.3%	

Freetext comments

Out of the **404** records audited, **176** (43.5%) had comments recorded on the Excel sheet. Examples of comments from reviewers which indicated that records were of good quality are shown below:(full text Appendix 2)

Positive comments

(χ) A good record using all relevant information sheets and Health promotion Programmes
(δ) Clear, concise and relevant
(ε) Comprehensive
(ϕ) Evidence of action planning
(γ) Evidence of forward planning.
(η) Generally high standard.
(ι) Good example of how new SAM would work.
(φ) Good quality record, clear and organised
(κ) Informative record good content, plan and review.
(λ) New records much easier to work with
(μ) Precise and legible
(ν) Records continue to improve
(ο) The new record appears to show how much better we are at record keeping with lots of relevant info, compared to the old records
(π) Very good quality record

Examples of freetext comments from reviewers which raised concerns about the quality of records reviewed are shown below (full text Appendix 2)

Observations of sub optimal record keeping

(δ) Action plan not completed for every entry.
(ε) Allergies was not asked
(ϕ) Basic info missing
(γ) Blank Spaces in notes- notes could be added to. Lines need to be drawn through spaces
(η) Blue ink used to write in notes
(ι) Change of HV previous HV documentation not up to standard
(φ) Chronology blank
(κ) Difficult to read at times

(ε) Domestic abuse. No analysis of impact on child.
(ϕ) Requiring minor adjustment
(γ) GP practice is merging at present which is why information was not completed.
(η) I have indicated areas for improvement within notes for attention
(ι) I would not ask parents with babies re-allergies until older and record then, so this may be why allergies has a N, as others in the team are the same
(φ) Information sharing was not signed
(κ) Name only written on some of the forms
(λ) No 1 year review. Seen at 38 weeks, then not until 27 month review. Notes very sparse.
(μ) No allergy status or age of baby
(ν) No CHI or names on pages
(ο) No std writing
(π) Reference to an event or parental request but not clear
(θ) School Record. Child new to area therefore some detail not included
(ρ) Some legibility issues
(σ) Staff reminded of NHS Grampian record keeping guideline
(τ) Time missing frequently
(υ) Time not always in 24 hour clock mode.
(ϖ) Time not entered at drop in baby clinics
(ω) Too young for assessment tool 6 weeks
(ξ) Where N is indicated this is primarily due to an HV who has retired
(ψ) Writing small and a little difficult to read

5 comments have been categorised as 'neutral for reporting purposes (full text Appendix 2)

Neutral comments

(ϕ) Abbreviations used THV I surmise means trainee health visitor but this is in the action plan
(γ) No errors in notes, so X score
(η) Plan; open access to the health visiting service
(ι) Vacant caseload
(φ) Phased retirement. Other HVs Covering

DISCUSSION/CONCLUSION

The trend line in Fig 1 is indicative of a gradual upwards improvement in the standard of record keeping amongst Health Visitors during the audit period. With the average audit score of records being **87.3%** during the audit pilot period; a dip in the middle quarter and a consistent levelling off, with records scoring an average of **94%,** in the last quarter of the audit - a **6.5%** improvement.

Appendix 3 illustrates the scores achieved by individual criterion in ascending order.
The following have been identified as the highest scoring criteria.

Top five scoring criteria:

- (γ) 99.8% Is the record free from jargon/meaningless phrases?
- (η) 99.8% Is there written information for each contact?
- (ι) 99.3% Are ALL entries signed?
- (φ) 99.0% Is the record free from speculation or opinion based statements?
- (κ) 99.0% Child's address (incl Postcode) completed

The following have been identified as the poorest scoring criteria.

Bottom 5 scoring criteria

- (η) 28.7% Are ALL errors timed using the 24-hour clock?
- (ι) 42.6% Are ALL errors dated?
- (φ) 43.6% Are ALL entries timed using the 24-hour (00:00) clock?
- (κ) 53.0% Is there evidence that the patient has been asked about allergies and/or previous reactions?
- (λ) 74.1% Are ALL errors initialled?

Results for individual criteria have been categorised into traffic light colours to help illustrate which areas Health Visitors are performing well in and where there are concerns. However the score for each criteria should be considered carefully. For example, is it acceptable for the Chronology not to be completed in nearly 9% of records?

Criteria asking whether there was evidence in the record of the child and their parent being involved in discussion regarding their needs/action plan scored highly indicating that the records are person centred in respect of involvement. Further quality improvement activity should incorporate other elements of person centeredness such as:

- (ι) Is there evidence of what information the child/carer need to allow them to achieve their goals?
- (φ) The level and amount of contact available/desired to/by the child/expectant mother/carer? and
- (κ) "What/who matters to them (the child and parent/family) to give them the best possible care?

Teams were tasked with reviewing their audit results on a monthly basis throughout the audit period and the audit pack allowed them to record their planned improvements so they could share with their team and learn from this. Anecdotal feedback from staff auditing the records was mixed. Most staff feeding back found the process useful and the audit helped them identify issues and manage this within their Teams. Some Teams reported that due to changes in staffing and staff shortages/vacancies that they found it difficult to manage the audit and there was some misunderstanding around which cases were to be selected for audit.

There was discussion at the November 2016 C&YPCN Records Group meeting around the requirement for continuous audit of records so that standards don't slip in between audits and to provide assurance that we as an organisation can provide, and actively reflect on real time data which drives improvement. There has also been discussion around developing a qualitative peer review audit which could link in with the 'Reflective Discussion' element of the NMC Re-Validation.

It needs to be considered where and how Professionals write down that a record has been audited with the date. Similarly, if there are any concerns with the quality of the record or the professional competence of staff completing a record – how is this managed?

Further quality improvement activity in respect of child records in the community should be mindful that the C&YPCN group are working towards an electronic record and how audit or similar is built into this; Allied Health Professionals are doing a qualitative peer review audit which the Group could learn from and there is innovative work being progressed in patient records across NHSG.

Finally, but arguably most importantly, the records should actively demonstrate that the child and those that are important to them are safe from harm, and that Public Protection concerns have been assessed, identified and managed appropriately. Various risk assessments are already in place such as GIRFEC and 'My World Triangle' and the chronology of the record identifies, records and actions significant events to facilitate this. Staff working with children and young people should have knowledge of the recently produced Public Protection e-cards available on the 'Public Protection' webpage on the NHS Grampian intranet. Not limited, but potentially linked to Child Protection, these signpost staff to what to do/who to refer to for any public protection concerns – e.g. Fire risk, Female Genital mutilation, Domestic abuse, Child Exploitation, Financial abuse and each card contains the strap line 'Recognise, Respond, Report, Record, Reflect'. In light of this the C&YPCN Records Group may also want to consider how Public Protection Concerns are recorded and subsequently audited within the record.

IMPROVEMENT PLAN (to complete) List action, by who and date achieved

- Share results with C&YPCN Sector Leads and discuss next steps:
  - continued/ future audit
  - follow up from actions
  - SBAR report to be completed by all Sector Leads (Moray, Aberdeenshire, Aberdeen City) and submitted to by End of June 2017
- Recommendations from SBARs implemented, August 2017

ACKNOWLEDGEMENTS

All School Nursing and Health Visitor teams taking part in the audit.
Tanya Johnston, Clinical Effectiveness Facilitator
Blair Watt, Clinical Effectiveness Analyst, NHS Grampian

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APPENDICES

- Data collection form
- Full Freetext comments
- Criteria scores in ascending

APPENDIX 1

Data Collection Form ~ Public Health Nursing Record Keeping Audit 2015/16

Q	Identification Data		Record 1	Record 2
1	Child's Forename and Surname on every sheet/booklet that has been used	y/n/p		
2	Child's CHI Number (10 digits) on every sheet/booklet that has been used	y/n/p		
3	Child's address (incl Postcode) completed	y/n/p		
4	Child's Sex	y/n		
5	Primary Carers Name (check page 5 of record)	y/n/p		
6	Primary Carers Contact Number (incl dialling code)	y/n/p		
7	GP's practice	y/n/p		
8	Parental rights and responsibilities (Mother)	y/n/p		
9	Parental rights and responsibilities (Father)	y/n/p		
10	Current Health Visitor/School Nurse name	y/n/p		
11	Current Health Visitor/School Nurse contact details	y/n/p		
	Legibility		**Record 1**	**Record 2**
12	Are ALL entries legible?	y/n/p		
13	Are ALL entries written in black ink?	y/n/p		
	Dates and signatures		**Record 1**	**Record 2**
14	Are ALL entries signed?	y/n/p		
15	Are ALL entries dated?	y/n/p		
16	Are ALL entries timed using the 24-hour (00:00) clock?	y/n/p		
17	Does the clinical record include a means of identifying the signature and designation of the person making the entries?	y/n/p		
18	Are entries made by pre registered nursing students countersigned by a registered nurse?	y/n/p/x		
	Allergies		**Record 1**	**Record 2**
19	Is there evidence that the child/parent has been asked about allergies and/or previous reactions?	y/n/p		
	Enhancement of Accuracy		**Record 1**	**Record 2**
20	Is there written information for each contact?	y/n		
21	Are ALL errors scored out with a single line?	y/n/p/x		
22	Are ALL errors initialled?	y/n/p/x		
23	Are ALL errors dated?	y/n/p/x		
24	Are ALL errors timed using the 24-hour clock?	y/n/p/x		
25	Are entries free from abbreviations? (NOTE : Except those in Appendix 37 of NHS Community Child Nursing Record Keeping guidelines 2015)	y/n		
26	Is the record free from jargon/meaningless phrases?	y/n		
27	Is the record free from speculation or opinion based statements?	y/n		
28	Is the record free from blank spaces?	y/n		
29	Are entries written in chronological order?	y/n		
30	Is the chronology up to date and consistent with the content of the record?	y/n		
31	Are all entries relevant and based on record keeping guidance?	y/n		
	Need identification Assessment and Care		**Record 1**	**Record 2**
32	Is there evidence that an assessment of need has been carried out?	y/n/p		
33	Is there an individualised action plan for identified needs?	y/n/p		
34	Is there evidence that the Child was involved in discussion regarding their needs/ action plan? (may not apply – FAQs)	y/n/p/x		
35	Is there evidence that the parent/carer was involved in discussion regarding the child's needs/action plan? (may not apply – see FAQs)	y/n/p/x		
36	Is there evidence that the action plan has been updated when a new need arose?	y/n/p		

APPENDIX 1

Data Collection Form ~ Public Health Nursing Record Keeping Audit 2015/16

37	Are action plans SMART (Specific Measurable Achievable Realistic Timely)?	y/n/p		
38	In your professional opinion does the time lapse between review dates appear appropriate?	y/n/p		
39	Is the information provided within the record easily understandable in communicating the child's needs to a professional who does not know the child?	y/n/p		

Comments Full Text **APPENDIX 2**

2. 24 hour clock needs to be consistent
3. 24 hour clock needs to be consistent
4. 24 hour clock not consistent
5. 24 hour clock not consistent
6. 24 hr clock
7. 24 hr clock
8. 24 hr clock
9. A good record using all relevant information sheet and Health Promotion Programmes
10. Abbreviations used THV I surmise means Trainee Health Visitor but this is in the action plan
11. Action plan not completed for every entry.
12. All areas filled in correctly
13. Allergies was not asked
14. Allergy not asked
15. Allergy not recorded time missing frequently
16. Analysis satisfactory
17. Area of information not written especially name on each page
18. Areas of information missing eg name and chi on all pages
19. As before
20. Basic info missing
21. Basic info missing
22. Basic info missing
23. Blank Spaces in notes- notes could be added too. Lines need to be drawn through spaces
24. Blank spaces in notes. No record of allergies
25. Blue ink used to write in notes
26. Change of GP/HV details not updated.
27. Change of HV previous HV documentation not up to standard
28. Change of surname not followed on sheets
29. Child with additional needs.
30. Chronology
31. Chronology blank
32. Chronology blank
33. Chronology blank
34. Chronology not opened.
35. Chronology not opened. Time not in 24 hour clock.
36. Chronology not up to date
37. Clear record,
38. Clear, concise and relevant
39. Comprehensive
40. Counter signatures required
41. Different bank staff adding to notes.
42. Difficult to read at times
43. Domestic abuse. No analysis of impact on child.
44. Easier to see entries easier in new records
45. Evidence of action planning
46. Evidence of forward planning.
47. Evidence that issues with records times /dates etc has improved ++
48. Factual record
49. Generally high standard. Good example of how new sam?? would work.
50. Good

Comments Full Text

APPENDIX 2

3. Good clear information - well done
4. Good documentation in record
5. Good quality documentation
6. Good quality record
7. Good quality, clear and organised
8. Good record
9. Good record
10. Good record
11. Good record
12. Good record
13. Good record
14. Good record
15. Good record
16. Good record
17. Good record requiring minor adjustment
18. Good record.
19. Good standard
20. Good standard
21. Good, but no allergy status or age of baby
22. Good, but no allergy status, no age of baby
23. Good, day date and time present but no age
24. Good, day date and time present. No age.
25. GP practice is merging at present which is why information was not completed.
26. I have indicated areas for improvement within notes for attention
27. I would not ask parents with babies re allergies until older and record then, so this may be why allergies has a N, as others in the team are the same
28. Information sharing not signed
29. Information sharing was not signed
30. Informative record, writing small and a little difficult to read, but good content, plan and review.
31. IT record only. No written notes. Record appropriate
32. Mainly good however 24 hour clock & allergy info needs to be consistent
33. Minor adjustments
34. Most records reviewed to a high standard
35. Name missing from some pages
36. Name only written on some of the forms
37. Need for 24 hour clock and times to be inputted. Need to watch for abbreviations
38. New records much easier to work with
39. New staff member, good analysis
40. New to area Current HV not visited family yet
41. New to area records
42. New to country. Limited early information.
43. New to country. Older child therefore initial contact from HV only.
44. No 1 year review. Seen at 38 weeks, then not until 27 month review. Notes very sparse.
45. No allergy
46. No CHI or names on pages
47. No errors
48. No errors
49. No errors
50. No errors in notes so X score
51. No errors in notes so x score, no std writing

Comments Full Text

APPENDIX 2

4. No errors in notes so X score, no student writing
5. No errors in notes so x score, no student writing
6. No errors in notes, so X score
7. No errors in notes, so X score, no student writing
8. No errors in notes, so X score, no student writing
9. No errors, record commenced by another HV team
10. No information sharing signed
11. No std writing
12. No std writing
13. No std writing
14. No std writing
15. No std writing
16. No std writing no errors
17. No std writing no errors
18. No std writing no errors in notes
19. No std writing, no errors
20. No std writing, no errors
21. No std writing, no errors
22. No std writing, no errors
23. No std writing, no errors in notes
24. Not enough room to input all error data.
25. Organised record. Has had change of HV
26. Partial IT record. Appropriate record keeping
27. Phased retirement. Other Covering
28. Phased retirement. Other Covering
29. Phased retirement. Other Covering
30. Phased retirement. Other Covering
31. Phased retirement. Other Covering
32. Phased retirement. Other Covering
33. Plan; open access to the health visiting service
34. Record precise and legible
35. Record legible, and factual
36. Record well documented
37. Record well documented
38. Record well documented
39. Record well documented
40. Record well documented and completed to required standards
41. Record well documented. All areas completed.
42. Records continue to improve
43. Records good content,
44. Records improving with time.
45. Reference to an event or parental request but not clear.
46. Review of errors
47. Satisfactory some inconsistency in time recording
48. Satisfactory minor error
49. Satisfactory minor errors
50. School record new to area some details missing
51. School Record. Child new to area therefore some detail not inc
52. Similar to 1st record audited.
53. Some birth details missing otherwise well documented records

Comments Full Text APPENDIX 2

5. Some day and 24hr clock missing
6. Some legibility issues
7. Staff nurse completed audit
8. Staff nurse completed audit
9. Staff reminded of NHS Grampian record keeping guideline
10. The new records appears to show how much better we are at record keeping with lots of relevant info, compared to the old records
11. The record shows improvement it the last entries recoreded.
12. Time not added when children attend the drop in baby clinic.
13. Time not always in 24 hour clock mode.
14. Time not entered at drop in baby clinics
15. Time on all entries.
16. Time, 24hr clock
17. Too young for assessment tool 6 weeks
18. Vacant caseload
19. Vacant caseload
20. Vacant caseloads. Staff shortages
21. Vacant caseloads. Staff shortages
22. Very clear plan for the child
23. Very clear record
24. Very clear record
25. Very good quality record
26. Very good record
27. Very specific clear record
28. Well documented record
29. Well documented records
30. Well written/recorded notes
31. Where N is indicated this is primarily due to an HV who has retired

Are ALL errors timed using the 24-hour clock?	28.7%	4.6%	78.7%	0.0%	n=121
Are ALL errors dated?	42.6%	1.9%	56.5%	0.0%	n=109
Are ALL entries timed using the 24-hour (00:00) clock?	43.6%	31.2%	25.2%	0.0%	
Is there evidence that the patient has been asked about allergies and/or previous reactions?	53.0%	0.7%	44.8%	1.5%	
Are ALL errors initialled?	74.1%	1.9%	25.0%	0.0%	n=109
Is the record free from blank spaces?	76.2%		23.8%	0.0%	
Child's CHI Number (10 digits) on EVERY sheet/booklet that has been used	77.7%		10.9%	0.2%	
Are ALL errors scored out with a single line?	77.8%	3.7%	18.5%	0.0%	n=108
Are entries free from abbreviations? (NOTE : Except those in Appendix 37 of NHS Community Child Nursing Record Keeping guidelines 2015)	84.9%				
Is there evidence that the Child was involved in discussion regarding their needs/ action plan? (may not apply - see FAQs)	85.7%	0.0%	14.3%	0.0%	n=35
Child's Forename and Surname on EVERY sheet/booklet that has been used	87.4%	6.2%	6.2%	0.0%	
Does the clinical record include a means of identifying the signature and designation of the person making the entries?	88.1%	8.4%	3.5%	0.0%	
Are action plans SMART (Specific, Measurable, Achievable, Realistic, Timely)?	89.1%	2.7%	3.7%	4.5%	
Current Health Visitor/School Nurse name	90.8%	0.7%	8.4%	0.0%	
Current Health Visitor/School Nurse contact details	91.3%	2.0%	5.7%	0.0%	
Parental rights and responsibilities (Father)	91.8%	0.2%	7.9%	0.0%	
Are entries made by pre registered nursing students countersigned by a registered nurse?	91.8%	2.0%	6.1%	0.0%	n=49
Is the chronology up to date and consistent with the content of the record?	92.8%		7.2%	0.0%	
Is there evidence that the action plan has been updated when a new need arose?	93.3%	2.0%	4.7%	0.0%	
In your professional opinion does the time lapse between review dates appear appropriate?	93.3%	0.0%	1.7%	5.0%	
Is there an individualised action plan for identified needs?	93.6%	1.7%	4.7%	0.0%	
Parental rights and responsibilities (Mother)	93.8%	0.0%	6.2%	0.0%	
Is there evidence that the parent/carer was involved in discussion regarding the child's needs/action plan? (may not apply - see FAQs)	94.4%	1.0%	4.6%	0.0%	n=393
Are ALL entries legible?	94.6%	4.5%	1.0%	0.0%	

[Status]**Criteria scores in ascending order** **APPENDIX 3**

Is there evidence that an assessment of need has been carried out?	95.3%	1.0%	3.7%	0.0%
Is the information provided within the record easily understandable in communicating the child's needs to a professional who does not know the child?	96.3%	3.2%	0.5%	0.0%
Primary Carers Contact Number (incl dialling code)	96.8%	1.2%	2.0%	0.0%
GP's practice	97.0%	1.0%	2.0%	0.0%
Child's Sex	97.8%	0.0%	2.2%	0.0%
Primary Carers Name (check page 5 of record)	97.8%	1.2%	1.0%	0.0%
Are entries written in chronological order?	97.8%		2.2%	0.0%
Are ALL entries written in black ink?	98.0%	0.0%	1.7%	0.0%
Are ALL entries dated?	98.8%	0.2%	0.7%	0.2%
Are all entries relevant and based on record keeping guidance?	98.8%		1.2%	0.0%
Child's address (incl Postcode) completed	99.0%	0.2%	0.7%	0.0%
Is the record free from speculation or opinion based statements?	99.0%		0.7%	0.2%
Are ALL entries signed?	99.3%	0.2%	0.5%	0.0%
Is there written information for each contact?	99.8%		0.2%	0.0%
Is the record free from jargon/meaningless phrases?	99.8%		0.2%	0.0%

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7. Clinical Effectiveness Team
8. Clinical Governance Coordinators/Facilitators: Janice Rollo, Ashleigh Allan
   Note: For cross sector circulation to groups/committees within own sectors
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Note:For cross circulation with Teams

Electronic Version of Executive Summary published on the Document Management System of NHS Grampian intranet Keywords: Audit, 2016, Record Keeping, Nursing, Community, Public Health, Children, School Nurse, Health Visitor

Executive Summary also available from the Quality, Governance & Risk Unit webpage and listed under 'Most Recently Added' within the 'Clinical Audits Completed' folder Project ID:2879

MORAY INTEGRATION JOINT BOARD (MIJB) CLINICAL & CARE GOVERNANCE COMMITTEE
SECTOR REPORTING FRAMEWORK

SECTOR:	Primary Care Contracts Team (PCCT)	**DATE OF MEETING:**	2 February 2018
TITLE:			
PURPOSE:			

KEY ISSUES:

1. NEW AREAS OF CONCERN

	Level of Risk *Low, Medium, High, Very High*	***Risk Register ID***	***Issue for concern***	***Planned action / Outcome***
a)	New Scottish Contract		With the new contract there will be varying changes to workload for all contractors and for PCCT. There are potential issues relating to sustainability within non GP contractors. PCCT are being requested to put out communication particularly for pharmacists being recruited by GP practices and GPs being recruited by other NHS G practices	Service Manager will be around all discussions relating to changes of contract etc. PCCT require to understand the contract fully and be ready to make any changes to practice contracts
b)	Sustainability		Sustainability across GP Practices is deemed as a very high risk.	Work is being done to support all HSCP around the issue of sustainability. As this is a big learning curve for PCCT members, Service Manager is undertaking most of this work. Need to develop other members of staff to support HSCP colleagues. Service Manager linking with Moray HSCP colleague who is seconded to 'sustainability post'
c)				

2. PROGRESS AGAINST AREAS OF CONCERN PREVIOUSLY REPORTED

	Level of Risk when first reported	***Risk Register ID***	***Previously reported Issue***	***Planned action***	***Update – Is this issue still a Concern?***	***Level of risk Now***
a)	Scottish Dental		Internal Auditors	All actions recommended were undertaken and	No longer a concern	

	Access Initiative (SDAI)		expressed concern about the monitoring process of the SDAI	the SDAI management and monitoring is very robust and there is a high assurance around dental practices compliance with aspects of the grant.		
b)						
c)						

3. ADVERSE EVENTS *(please report on the lessons identified from major and extreme incidents)*

There have been no adverse events with PCCT

4. PROGRESS ON IMPLEMENTING RECOMMENDATIONS FROM OMBUDSMAN CASES

N/A

5. AREAS OF ACHIEVEMENT AND GOOD PRACTICE

a) The changes made within the SDAI management and monitoring practice is most certainly an area of achievement and is now consistently good practice.

Communication channels with all leads and contractors groups have developed over the last few years to the point where team members are known to most clinical leads/contract leads and contractors. The team have worked hard at making this possible and, in general, confidence is now high regarding the individual functioning of team members.

b) The Service Manager is taking the PCCT through organisational change process; the PCCT and how it performs needs to be revised in order to maximise its efficiency, effectiveness and quality of service**.** Most recently the team lost 2 members of staff who left the organisation.

Team stability is critical to this process of maximising efficiency.

The use of temporary, acting up and bank staff undermines this stability. In order to return to a highly functioning, flexible, team a process of organisational change is taking place, effectively giving stability and streamlining of role and function of all team members.

6. ITEMS TO BE REMOVED FROM REPORT

	Level of Risk when first reported	***Risk Register ID***	***Previously reported Issue***	***Planned action***	***Update – Is this issue still a Concern?***	***Level of risk Now***	***Remove from report?***
a)							
b)							

c)							

RECOMMENDATIONS: The Moray IJB Clinical & Care Governance Committee is asked to note this report and the actions taken.

Name:	Patricia Morgan	**Designation:**	Service Manager Primary Care Contracts	**Date:**	15th January 2018

Review of Clinical and Care Governance Arrangements

Name of Service.....Primary Care Contracts (PCC) Team.....

Area	Sub section	Current arrangements	Evidence	Actions identified
Governance	Clinical Governance Arrangements • Service	Service Manager Primary Care Contracts (PCC) has statutory responsibility for the Control of Entry onto all 4 contractor lists (Dental, Pharmacy, GMS, and Optometry). Control of Entry is guided by legislation. Senior Admin Workers are delegated responsibility within PCC Team (PCCT) Monthly Decision Circulars are received by PCCT to identify any GMC;GPC;GDC condition/ case relating to specific contractors. Pharmacy Decision Circulars are dealt with by Director of Pharmacy Formal Medical, Pharmacy, Dental and Ophthalmic Payment Verification (PV) Assurance Meetings are held quarterly. PV issues and clinical governance issues are dealt with on an ongoing basis, as they arise during the course of the year, and are fed through a number of performance and management groups across all contractor areas and within local Health and Social Care Partnership (HSCP) performance management structure as appropriate. PV meeting identify over/under achievers in relation to income, which can have often suggest issues in care and treatment.	Performers List Decision Circulars; any emails required with information from the team or from others in larger Primary Care Team PV Audit Reports detailing all 4 contractor areas PV Reports Minutes of meetings – Audit Committees; PV Meetings Pharmacy Performance & Governance Committee; Dental Performance & Governance Committee; all Contractor Enhanced Service Group	
Risk	Risk Management Arrangements • Service	Primary Care Contracts record on Risk Management report any risk related to the robust service delivery to the HSCP and others, both contractors and the larger (NHS G) primary care team Any risks are reviewed regularly during both PCCT huddle and contract performance huddle – both chaired by Service Manager	Risk register; huddle notes Minutes of meetings.	

		PCC Any contractual risks will be identified and flagged to relevant HSCP for assessment of inclusion in local Risk Register Internal Team risks are identified through incident recording reporting and dealt with internally unless escalation is required.		
	Identification of service-specific risk triggers	Regular Audits are taken both within the team and from Internal Auditors Recent audits include Scottish Dental Access Initiative (SDAI) and Family Health Service (FHS) Contract Management. The 2018 General Medical Services Contract in Scotland may impact on all contractors and given the requirement for Multi Disciplinary Team could impact on sustainability in other contractor areas	SDAI monitoring process is robust and continues to be supported and managed appropriately Outcomes paper, from FHS Audit provides assurance that opportunities have been taken to streamline and better manage governance and performance monitoring.	
	Risk Assessment	Risk assessments completed by Service Manager and where appropriate in partnership with HSCP SG tools are utilised to support risk assessments.	Sustainability Tool 'the Welsh tool'	
	Risk Escalation	Risks escalated via Service Manager through Head of Service Moray HSCP and to relevant HSCP clinical leads or/and Primary Care Leads. Work in partnership to identify appropriate actions.	Moray HSCP risk plan	
	Risk Control Plan • Service	All appropriate risks that require be escalating or recording are done so through the Moray HSCP Risk Control Plan. Risks relating to other HSCPs are also escalated via the Clinical Leads and PC Managers and these are then identified within Local Risk Plans	Copy of plans	
Complaints	Local Process • Individual responsibilities • Timescales • Escalation • Ombudsman	NHS G Feedback Service sends quarterly report to all contractors through Lime Survey. Contractors required to complete and return; All contractors do not complete this is picked up via clinical leads for the contractor area. Feedback Service no longer report through Information Services Division (NNHS) will be reporting through clinical governance etc and	Lime Survey return/Quarterly reports. Minutes of meetings Datix reports	

		the Primary Care team. Any issues will be fed through PV and other contract specific Performance and Governance committees. Other complaints are reported through NHS G Datix system; dates and times for responding and identification of responders are all within the system when alert is sent.		
	Analysis – identification of trends/transferrable lessons	Via Datix system; internal PCCT complaints would be reported through the Service manager and kept within a complaints log.		
	Reporting			
	Sharing of information • Service	Complaints and risks are also fed a variety of other management groups; often those sub groups of the Primary Care Implementation Management Group which has representation from all NHS G contractor group leads and PC Managers. Also through Team meetings; Huddles etc	Minutes of meeting Communication trails.	

Incidents	Reporting			
	Management of reported incidents (approval)	Datix system; this identifies first responders and anyone who is required to comment; approvers are also identified through this system. Internal within the PCCT staff would be required to put together an Incident report detailing the issue and Service Manager would review and asses.	Datix reporting and responses Incident reports/error reports and review paperwork.	
	Investigation of high/very high incidents	If incidents merits; this would be entered into Datix and also fed up to Head of Service Moray HSCP; also to clinical leads and PC Managers in other HSCPs		
	Use and analysis of incident data (reports etc.)	Incident data reviewed and taken account of in improvement to service or changes in working procedures. This would be expected to be the case in other areas.	FHS Audit paperwork SDAI Audit – change to systems working. Dispensing Review	
	Identification of trend/transferable lessons	Via datix/ incident review reports/management meetings; performance and governance meetings; team meetings; huddles	Minutes of meetings Incident logs Datix log	
	Sharing of learning outcomes	This is done in different ways; through reports to committees; management groups etc; internally done through team meetings/huddles etc**.**		
Clinical Practice	Management of – who, when, frequency, how?	Workload within PCCT can be variable and Bank staff and temporary members of staff are used regularly.		
	Sources of assurance	Weekly Huddles with full team; monthly performance and governance meetings with individual member of staff and contract lead Protected 1-1 time with each member of staff. Service Manager reports to NHS G Audit Committee on yearly basis and to Moray HSCP; audit is also shared with HSCPs City and Aberdeenshire	Minutes of meetings/huddles Audit paperwork and minutes of meetings.	
	Documentation – forms, records, record keeping etc.	Audit reports and paperwork Internal paperwork and processes are developed where there is no national or NHS G process or paperwork.	SDAI monitoring and recording process PCCT developed SOPs	
	Policies, protocols etc. – updating of existing and development of new	SOPs reviewed regularly by team but also in partnership with NHS G contractual Leads	SOP review and check list.	

	Triggers	Change in or new legislation	SOPs	
	Escalation	Escalation would be through team member to Service Manager; this would then be escalated through Head of Service Moray HSCP and clinical leads and PC leads for other HSCPs	Minutes of discussions and meetings Communication trails	
Education & Training	Availability of/access to appropriate training • Mandatory • Compulsory • Service • National	All staff members are registered with eKSF and have access to all compulsory training. The Manager is able to review completion of all compulsory or mandatory training. All staff have PDPs and objectives	eKSF system PDPs	
	Training needs analysis	All staff have protected time 1-1 with Service Manager and are able to identify learning needs together. All have access to NHS G L&D training plan and any national training etc can be accessed if appropriate. If/when changes in role or legislation occurs learning is assessed and staff have access.	Given Organisational Change process taking place within the PCCT; all learning plans and objectives etc are/will be reviewed	
	Clinical Supervision	There is no clinical supervision with the PCCT as there is no direct contact with patients. All members of staff have protected 1-1 time on a six weekly basis with Service Manager; all are involved in performance and governance meetings on a monthly basis, with Service Manager and contract lead for NHSG. Service Manager operates an 'open door' policy where team members can access when required.	Notes of 1-1 meetings; Notes of P&G Meetings	
Professional Development	Continuing Professional Development	Protected 1-1 time with Service Manager PDPs through eKSF	PDPs Notes on 1-1	
	Appraisal/assessment of competency	Staff should have appraisals every 6 months. Staff also have 6 weekly protected time with Service Manager	Notes of 1-1 Appraisal paperwork.	

Standards/ Evidence Based Practice	HIS(Healthcare Improvement Scotland) CI (Care Inspectorate) Standards			
	SIGN (Scottish Intercollegiate Guidelines Network)Guidelines			
	NICE (National Institute for Health & Care Excellence) guidance			
	Professional/college guidelines (e.g. SSSC Scottish Social Services Council / NMC Nursing and Midwifery Council)			
External Review /Inspection	HIS/CI peer review – review outcome and subsequent action plan			
	HEI (Healthcare Environment Inspectorate)			
	Others e.g. MWC (Mental Welfare Commission)			
Performance Review	Structure			
	Frequency			
	Representation			
	Format/template/ documentation			
	Escalation process			
Legal/litigation	Process for handling			
Person Centred Care	Service user engagement			

Completed by.....

Date.....

MORAY INTEGRATION JOINT BOARD (MIJB) CLINICAL & CARE GOVERNANCE SUB-COMMITTEE
SECTOR REPORTING FRAMEWORK

SECTOR:	Community Pharmacy	**DATE OF MEETING:**	2nd February 2018
TITLE:	Review of Clinical and Care Governance Arrangements in Community Pharmacy		
PURPOSE:	To provide information on the clinical and care governance framework developed to monitor community pharmacy		

KEY ISSUES:

1. NEW AREAS OF CONCERN

	Level of Risk *Low, Medium, High, Very High*	***Risk Register ID***	***Issue for concern***	***Planned action / Outcome***
a)	High		Dispensing errors remain 'criminal' acts, inhibiting reporting of dispensing errors.	General Pharmaceutical Council is lobbying parliament. Legislation is in the process of being amended. This is likely to encourage more open reporting of dispensing errors
b)	Medium		Community pharmacies are independent contractors making governance engagement complex.	Attempts are made to encourage community pharmacists to become members of the various groups/committees delivering a governance function. Funding can be made available to cover locum costs.
c)	Medium		Staff resource to carry out regular visits to community pharmacies – 26 community pharmacies in Moray	Visits can be undertaken so long as minimum of two relevant agencies are involved – HSC Moray, Pharmacy and Medicines Directorate, Primary Care Contracts Team.

2. PROGRESS AGAINST AREAS OF CONCERN PREVIOUSLY REPORTED – *N/A, first report to committee*

	Level of Risk when first reported	***Risk Register ID***	***Previously reported Issue***	***Planned action***	***Update – Is this issue still a Concern?***	***Level of risk Now***
a)						
b)						

c)						

(e)	**ADVERSE EVENTS *(please report on the lessons identified from major and extreme incidents)***
	No major or extreme incidents identified
(f)	**PROGRESS ON IMPLEMENTING RECOMMENDATIONS FROM OMBUDSMAN CASES**
	N/A
(g)	**AREAS OF ACHIEVEMENT AND GOOD PRACTICE**
b	Engagement between community pharmacies and medical practices to improve communication and working practices.
c	Delivery of minor ailment services to reduce requests for appointments at medical practices
(i)	**ITEMS TO BE REMOVED FROM REPORT -** *N/A, first report to committee*

	Level of Risk when first reported	***Risk Register ID***	***Previously reported Issue***	***Planned action***	***Update – Is this issue still a Concern?***	***Level of risk Now***	***Remove from report?***
a)							
b)							
c)							

RECOMMENDATIONS: The Moray IJB Clinical & Care Governance Committee is asked to note this report and the actions taken.

Name:	Sandy Thomson	**Designation:**	Lead Pharmacist	**Date:**	26 Jan 2017

Review of Clinical and Care Governance Arrangements

Name of Service: Community Pharmacy

Area	Sub section	Current arrangements	Evidence	Actions identified
Governance	Clinical Governance Arrangements • Service	• **Informal discussions** • **Pharmacy Performance and Governance Group (PP&GG) discussion** • **Director of Pharmacy (DoP)** • **General Pharmaceutical Council (GPhC)**	**Agenda for a meeting of the Pharmacy Performance & Governance Group** **Minute of the Meeting of the Pharmacy Performance & Governance Group held on Monday 2nd October 2017**	
Risk	Risk Management Arrangements • Service	**There is currently no Risk Register and this will need to be developed in conjunction with contractors with a target date of end 18/19**		
	Identification of service-specific risk triggers	**Pharmacy visits** **Payment Verification (PV) meeting** **GPhC inspector and local intelligence to identify risks and issues** **Tends to be reactive rather than proactive**	**Annual Community Pharmacy Contract Self-assessment Tool** **Primary Care Payment Verification Assurance Group** **Pharmacy - Minute Tuesday 19 July 2017** **PV Assurance Group – Pharmacy - Minute Monday 17 July 2017**	
	Risk Assessment	**Will need to be done to inform both the register and the risk control plan – see above**		
	Risk Escalation	**Same as under governance**		
	Risk Control Plan • Service	**To be done – see above**		

Complaints	Local Process • Individual responsibilities • Timescales • Escalation • Ombudsman	• **Community pharmacy incident logs** • **National multiple pharmacy chains have organisational reporting processes** • **Lime survey via feedback services** • **Datix reports** • **NHS Grampian Complaints procedure** • **Pharmacy visits** • **Performance and Governance group** • **DOP** • **GPhC** • **Duty of Candour**	**CP Datix 2017** **Handling of Datix Reports Within Pharmacy and Medicines Directorate Flowchart** **Draft NHS Board Error Template Letter** **GPhC statement on Duty of Candour** https://www.pharmacyregulation.org/sites/default/files/joint_statement_on_the_professional_duty_of_candour.pdf	
	Analysis – identification of trends/transferrable lessons	**We do not receive complete and good information from any one source, but use what we can to identify themes or specific issues**		
	Reporting	**Reporting is still not consistently and comprehensively done either from contractors to the health board or from feedback services to the performance and governance group.** **Dispensing errors remain 'criminal' acts.**		
	Sharing of information • Service	**We do have good routes for sharing information and intelligence both formally and informally, including Performance and Governance Group**		

Incidents	Reporting	**Incidents are reported at source through incident logs and where they get past that through Datix** **(Any incident identified out with the community pharmacy should be reported on Datix)**	See 'complaints'	
	Management of reported incidents (approval)	**Managed via Datix system**		
	Investigation of high/very high incidents	**Managed via Datix system.** **Professional review by GPhC disciplinary processes**	**GPhC 'raising concerns' process'** https://www.pharmacyregulation.org/raising-concerns/how-we-deal-concerns	

	Use and analysis of incident data (reports etc.)	**Managed via Datix system**	See 'complaints'	
	Identification of trend/transferable lessons	**Managed via Datix system**	See 'complaints'	
	Sharing of learning outcomes	**Incidents of note are escalated to the Pharmacy Performance and Governance Group, and ultimately to GPhC, the professional regulator.**		
Clinical Practice	Management of – who, when, frequency, how?	**Individual contractors are responsible for their clinical practice informed through Service Level Agreements (SLA), Standard Operating Procedures (SOP) (GPhC requirement) and guidance issued nationally or locally depending on the service**	**StandardOperating Procedure (Template)**	
	Sources of assurance	**Pharmacy visits** **Payment verification** **Performance and Governance Group**		
	Documentation – forms, records, record keeping etc.	**Standard guidance, recording and claim documentation is used where possible and some generic SOP templates are used where individual information is required**		
	Policies, protocols etc. – updating of existing and development of new	**NHSG Medicines Guidelines and Policies Group sanctioned policies and protocols used on a regular review programme**	**Medicine Guidelines and Policies Group (MGPG)**	
	Triggers	**The usual triggers for looking at clinical practice are the introduction of new service or identification of issues via performance and governance group**		
	Escalation	**Informal to performance and governance to DOP and GPhC**		
Education & Training	Availability of/access to appropriate training • Mandatory • Compulsory • Service • National	• **AT training access** • **NES training** • **Locally arranged training** • **RPS** • **Numark/NPA etc**		

	Training needs analysis	• **2017 education and training survey** • **New service introduction** • **Cycle of relevant subjects**	**CP Workforce Data** **CP List to Audit for 2018** **Community Pharmacy Education Survey Report**	
	Clinical Supervision	**Responsibility of individual contractors (may involve GPs where community pharmacist do clinics for a surgery)**		
Professional Development	Continuing Professional Development	**GPhC governing body CPD requirement for both pharmacists and technicians. Pending introduction of revalidation processes.**	GPhC standards for CPD: https://www.pharmacyregulation.org/standards/continuing-professional-development Revalidation weblink: https://www.pharmacyregulation.org/news/gphc-council-gives-green-light-implementation-revalidation-step-change-pharmacy-professionals	
	Appraisal/assessment of competency	**Up to individual contractors plus GPhC random selection**		

Standards/ Evidence Based Practice	HIS(Healthcare Improvement Scotland) CI (Care Inspectorate) Standards	✓		
	SIGN (Scottish Intercollegiate Guidelines Network)Guidelines	✓		
	NICE (National Institute for Health & Care Excellence) guidance	✓		
	Professional/college guidelines (e.g. SSSC Scottish Social Services	**GPhC and Royal Pharmaceutical Society** **HSCP and Pharmacy and Medicines**	Standards for Pharmacy Professionals: https://www.pharmacyregulation.	

	Council / NMC Nursing and Midwifery Council)	**Directorate**	org/spp Standards for Pharmacy Premises: https://www.pharmacyregulation.org/standards/standards-registered-pharmacies	
External Review /Inspection	HIS/CI peer review – review outcome and subsequent action plan	**GPhC inspectorate**		
	HEI (Healthcare Environment Inspectorate)	**Scottish Environmental Protection Agency para 18 sign up**		
	Others e.g. MWC (Mental Welfare Commission)			
Performance Review	Structure	**Local random pharmacy visits plus audit programme for various services. GPhC professional visits**	**CP List to Audit 2018**	
	Frequency	**Infrequent (~3-4 premises yearly) during pharmacy visits. Restricted due to lack of resource in both HSC Moray and Pharmacy and Medicines Directorate**	**Key Roles for Community Pharmacy in 2018**	
	Representation	**Pharmacy and Medicines Directorate, Primary Care Contracts Team, Health and Social Care Partnership**		
	Format/template/ documentation	**Standard data set and self-assessment tools and recording templates used**		
	Escalation process	**DOP and GPhC**		

Legal/litigation	Process for handling	**Payment Verification, Regulation, GPhC / Royal Pharmaceutical Society using 'Raising Concerns' and Fitness to Practice' standards**	Raising Concerns weblink: https://www.rpharms.com/res es/quick-reference-guide/raisi concerns-whistleblowing-and speaking-up-safely-in-pharmacy?utm_source=Royal 0Pharmaceutical%20Society& m_medium=email&utm_cam n=9049662_10012018%20BE 20inside%20out%20%28all% embers%29&dm_i=EQ,5DYE SO84,KUB10,1 Fitness to Practice weblink: https://www.pharmacyregulati org/form/fitness-practise-declarations
Person Centred Care	Service user engagement	**Contractor responsibility and area managers for multiples**	

Completed by: Sandy Thomson, Lead Pharmacist

Date: 15th January 2018