Integration Joint Board
Clinical and Care Governance Committee

2nd May 2019

This Report relates to
Item 4 on the Agenda

Community Health and Social Care Improving Safety – Reducing Harm

(Paper presented by Graham Abrines)

For Approval

Approved for Submission by	Graham Abrines , General Manager Community Health and Social Care
Author	Graham Abrines ,General Manager, Community Health and Social Care Mhairi Hastings, Lead Nurse, Community Health and Social Care Peter Bryden, Risk & Quality Improvement Manager
List of Background Papers	Not Applicable
Appendices	Appendix 1 – New Structure for Connecting Quality Agenda Throughout Directorate Appendix 2 - Example of Learning Summary Appendix 3 – Complaints Handling Process

Direction Required to Council, Health Board or Both	**Direction to:**	
	1. No Direction Required	x
	2. Dumfries and Galloway Council	
	3. NHS Dumfries and Galloway	
	4. Dumfries and Galloway Council and NHS Dumfries and Galloway	

SECTION 1: REPORT CONTENT

Title/Subject: Community Health and Social Care Directorate
Improving Safety – Reducing Harm

Meeting: IJB Clinical and Care Governance Committee

Date: 2nd May 2019

Submitted By: Graham Abrines / Mhairi Hastings / Peter Bryden

Action: For Approval

1. Introduction

1.1 This report outlines the work of the Community Health & Social Care Directorate in respect of the patient safety & reducing harm agendae during the last 12 months. Services in scope are primarily Health though, in line with a request from the Clinical and Care Governance Committee, the Social Care & Reablement Services delivered by the Directorate are also covered.

The Clinical and Care Governance Committee separately receives a report detailing the external scrutiny of regulated adult care services delivered by the Local Authority, presented by the Chief Social Work Officer. In addition, performance reporting in respect of social work activity is included as part of the Annual Performance Report which is submitted to the Integration Joint Board.

2. Recommendations

2.1 The Clinical and Care Governance Committee is asked to:

- **Note the work of the Directorate in respect of safety, risk mitigation & harm reduction.**
- **Discuss and agree that the actions proposed to address safety and or mitigate risk which will ultimately reduce harm are sufficient.**

3. Background

3.1 Community Health and Social Care encompasses the majority of community based Adult Health and Social Care Services throughout the region. The Directorate encompasses what was the Primary and Community Care Directorate and Adult Social Work Services, with the exception of the central (regional) learning disability service which sits in the Mental Health Directorate and the statutory mental health team, which is not a delegated service. The Local Authority Care at Home Service (CASS) and the joint Short Term Assessment and Reablement Service (STARS) are also part of the Directorate as are a number of regional health services, for example Out of Hours Health (OOH) medical service and the Forensic Medical Service (Police surgeons).

The workforce is extensive. All colleagues in professional posts require to be registered with their appropriate professional body:

- Allied Health Professionals (AHP) – Health and Care Professionals Council (HCPC)
- Nurses – Nursing and Midwifery Council (NMC)
- Social Workers/Social Care Staff – Scottish Social Services Council (SSSC)
- Doctors – General Medical Services (GMC)

Improvement, support, advice and scrutiny of the services provided by the Directorate are carried out by two main bodies: Healthcare Improvement Scotland (HIS) and the Care Inspectorate. These agencies also work in partnership; for example, both carried out the Joint Inspection of Health and Social Work Services for Older People in 2016.

HIS have a broad work programme, however within the Directorate the main areas of support come from the following departments:

- Healthcare Environment Inspectorate (HEI) supporting the reduction of healthcare associated infection to patients
- iHub – Supporting and linking our quality improvement initiatives locally and nationally in service design and provision
- Scottish Health Council (SHC) supporting the Directorate in areas where we need to involve the public in development of services
- Scottish Intercollegiate Guidelines Network (SIGN) who develop the evidence based clinical practice guidelines we use, for example, SIGN 116 and 154 Management of Diabetes
- Scottish Patient Safety Programme (SPSP) assisting us through the programme to reduce harm through improving the safety and reliability of healthcare, for example, identifying the deteriorating patient through implementation of the National Early Warning Score Tool
- Scottish Health Technologies Group who support our work in ensuring that emerging technologies and telehealth equipment are cost effective and have positive implications for people in our localities

Scrutiny is also provided by some of these same Departments, namely HEI, who inspect our hospitals to ensure they are safe and clean. Cottage hospitals have not, until very recently, been part of this regime.

The Scottish Health Council also provides a level of scrutiny regarding public consultation against the Participation Standard, as well as scrutinising any major service change consultations.

Healthcare Improvement Scotland scrutinise against the Care of Older People Standards within hospital settings. From 2017 this included cottage and community hospitals. Section 4.3 of this report 'Excellence in Care: Care Assurance' informs the improvement and assurance work we have been undertaking in cottage hospitals within the Directorate, to assure the care we provide is person centred, safe and effective – the same three national quality ambitions which HIS aim to assure.

The Care Inspectorate is a scrutiny body which supports improvement within Social Care. All of the regulated Social Care services that the partnership directly provided, for example CASS, or that it commissions via the Local Authority, for example, Care at Home providers and Care Homes are inspected by the Care Inspectorate. Where the Care Inspectorate find that improvement is required they will support services to make positive changes.

A qualified Social Worker's core function lies in the field of Public Protection. Quality assurance arrangements and audit work is carried out under the auspices of the Public Protection Committee (PPC). Where there are considered to be deficits in practice and where the criteria is met, cases will be considered via Initial Case Reviews (ICR's) or Significant Case Reviews (SCR's); learning from such reviews is shared. There has been significant work carried out over the past year to bring the work previously carried out by the Adult Support & Protection Committee under the wider scope of the PPC.

In addition to the above, the CH&SC Directorate Risk & Quality Manager undertakes, at least, monthly visits to each of the Directorate's facilities and also has a planned schedule of joint visits arranged with the NHS Board Health & Safety Advisor to provide feedback to teams regarding Health & Safety, Fire Safety and Security.

4. Main Body of the Report

4.1 Connecting Quality

Connecting Quality is the main focus for the Risk & Quality Management Team within the CH&SC Directorate (Strategic / Tactical). With the appointment of the new Risk & Quality Improvement Manager, replacing the Clinical Governance Officer role during 2018, Connecting Quality was subject to a review meeting in October where the terms of reference (TOR's) were reviewed and the membership re-focussed to take forward the Connecting Quality Agenda.

A subsequent meeting was held in December 2018 where the attendees ran through the previously agreed agenda and discussed how the then current position. As a result a paper was completed, outlining a proposed new structure and recommending work should focus on shifting to an "operational level up" approach as opposed to "Strategic level down". Work with localities is ongoing to identify how this will be best implemented and achieved.

The Risk & Quality Manager is part of the Directorate Senior Management Team and provides regular updates to the monthly SMT meeting.

See Appendix 1 – New Structure for Connecting Quality Agenda throughout the Directorate

4.2 Care and Support Services (CASS) / Short Term Assessment Reablement Service (STARS)

4.2.1 CASS

CASS is registered for two distinct functions with the Care Inspectorate, namely:

- Support Services Care at Home - this focuses predominantly on the delivery of personal care, medication administration, bathing and showering, hoisting tasks, food preparation/nutrition and general wellbeing etc
- Housing Support Services – this covers a range of services which help people to live as independently as possible, stay safe and secure, get help to engage with and gain assistance from other specialist services who can provide support with a range of services

As a registered service CASS is subject to an annual inspection (minimum), usually undertaken announced. These inspections seek feedback and engagement from Service Users, Staff and Stakeholders alike as well as perusing service specific questionnaires and reviews that have been undertaken by the service. As part of the guidance from the Care Inspectorate, the service undertakes a minimum of two reviews annually for service users (approximately 330 service users are supported by the service at any point in time), with more undertaken if required to meet individuals' changing needs. The latest Care Inspection was undertaken in April 2018.

The service is staffed exclusively from the Local Authority, with the staff employed on the Local Authority terms and conditions. All staff are given an annual Personal Development Review, as well as 1:1 meetings with line managers and relevant team meetings.

CASS utilises an external company's product, CM2000, to schedule, record and report on all activities. The service undertakes circa 300,000 visits a year and has achieved its KPI (Key Performance Indicator) target of 99.7% for Missed Visits (this is defined as a visit which has not been undertaken within 30 minutes of the allocated time - this target has never been breached and in fact remains at 100%). The service has provided all frontline workers (approx 250) with smart phones, on which they receive their staff rotas; this has allowed the service to be more reactive should changes be required, as well as being more secure than paper copies as staff effectively have access to a 'portal' to their information. The service is able to report on individual staff or service users, by team, by locality and regionally. Trends of activity can be captured very easily, as well as historical data that is often requested through Freedom of Information requests etc.

The service has robust contingency procedures that are tested throughout the year and at times of crises; due to the nature of the work in remote rural areas, weather

is the most common challenge to timely service provision. The service operates from 6am – 10.30pm 365 days per year and, in addition to frontline staff, have supervisors and managers available on standby. The Principal Manager is part of the Local Authority's Tactical Support Group and as a result has undertaken additional resilience and contingency training which has been cascaded to the operation of the services where appropriate.

CASS adheres to the Health and Social Care Standards ("The Standards") which are used by the Care Inspectorate when carrying out their inspections. The Standards and outcomes set out in "The Standards" are published under Section 50 of the Public Services Reform (Scotland) Act 2010 and Section 10H of the National Health Service (Scotland) Act 1978.

CASS, as an employer, is also governed by the Scottish Social Services Council (SSSC) Codes of Practice; in addition all Managers, Supervisors and Care and Support Workers now need to pay to register themselves individually and agree to meet the necessary minimum qualifications within a specified timescales. The Codes set out the following:

- The standards of practice and behaviour expected of everyone who works in social services in Scotland
- The standards expected of employers of social service workers in Scotland

This registration requirement will have a significant effect on CASS as a service; whilst supporting staff to be up-skilled is welcomed, it does come at a financial cost as well as the risk of potentially losing staff members who do not wish to undertake the necessary qualifications.

At the last Care Inspectorate Inspection, CASS was assessed on two areas - the quality of care and support, and the quality of staffing. In each case, these were graded as a 5 (very good), the second top grade on a six point scale.

There were no "requirements" ie improvement action that must be carried out, but there were three recommendations, as detailed below:

- The service provider should develop the personal plans, ensuring that interventions detailed are specific in nature, and support a consistent approach to care delivery linked to individual's wishes and preferences. This is to ensure that care and support is consistent with the Health and Social Care Standards which state: 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15).

- The service provider should ensure that where developments in staffs' practice are required, objectives set are specific, can be measured, and are linked to the grading system developed. This is to ensure that staffing is consistent with the Health and Social Care Standards which state: 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

- The service provider should encourage a culture of continuous reflection amongst the staff group. Reflection should be used to help staff evaluate their practice, enhancing the care and support they provide. This is to

ensure that staffing is consistent with the Health and Social Care Standards which state: 'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14).

4.2.2 STARS

STARS is perhaps a more complex service in nature; it is not a registered service. The complexity lies in the multi disciplinary groups of staff required to undertake the different aspects of reablement effectively. This is compounded by the service being comprised of NHS and Local Authority staff. Whilst the majority of the management and clinical teams are NHS staff, the supervisors and frontline staff are predominantly Council staff (approx. 80%/20%) split. This has brought challenges over the years in terms of Finance, HR, Terms and Conditions, IT etc but has steadily improved since the launch of the Partnership.

Best practice has been adopted from NHS and Council dependent on what was most effective or indeed established. The scheduling, recording and reporting of work, like CASS, is done using CM2000 and this has been effective in significantly improving 'hands on' patient time. Supervision is undertaken with Team Meetings etc and the appropriate paperwork followed up / completed, dependent on who is the main employer.

All staff are given Reablement Training which is done in conjunction with local colleges and with schools; the National Progressional Award (NPA), whereby credits can be used towards future study like SVQ in Reablement, was initiated in D&G by the Service Manager and, following accreditation, is now used throughout Scotland.

In order to support assessments and to capture the status of service users/patients, the service uses Indicator of Relevant Need (IoRN); these are practice/clinical and management tools for people delivering and planning care and support services. Used by professionals, the IoRN provides a summary of a person's functional needs and/or the degree of dependence/independence. Recording IoRN information takes minutes to do, yet delivers key information for frontline practice. Whilst other partnership areas use varying methods of recording data, the IoRN continues to be supported by ISD and NHS Scotland.

Any adverse incidents within STARS are recorded using the DATIX system.

STARS use the Turas digital platform for mandatory training; infection control; cardiopulmonary resuscitation (CPR); therapeutic responses to Aggression and Violence; Moving and Handling; Fire training; Child Protection; Awareness and Fairness; Adult Support and Protection (ASP). We built on Care Aware Training; Dementia Levels 1&2; and a bespoke practical workshop with Aggression and Violence lead for staff on practical approaches to reducing risk of harm/de-escalating or escaping potentially aggressive or violent incidents. Four members of the Management Team are Moving and Handling trained Facilitators.

In terms of Professional Practice Governance, the following is in place for each group of staff:

- SCNs (Senior Charge Nurses) – register every year with Nursing and Midwifery Council with revalidation every three years; this is supported by the Locality Nurse Managers.
- AHPs (Allied Health Professionals) – register with the Health and Care Professionals Council (HCPC) every two years
- OTAs (Occupational Therapist Assistants – fall within the national definition of Health Care Support Worker so have mandatory induction standards. These range from protection of patients from abuse, to whistle blowing, including observed practical demonstrations of aspects such as infection control, within the first three months of their employment.

4.3 Excellence in Care: Care Assurance

In follow up to last year's report, this is still a central focus throughout Health Care.

The approach to assure care has been taken forward under the banner of Excellence in Care (EIC) and builds on previous policies and work programmes. The framework builds upon the findings in the Vale of Leven inquiry report covering nine key areas: culture; leadership; governance; safety; sustainability; effectiveness; person centred; workforce and quality improvement.

The National Objective is that; the Scottish public has confidence and assurance that nursing and midwifery care is high quality, safe, effective and person centred and that this is the daily norm.

4.3.1 NHS Dumfries and Galloway

Measuring the quality of care being delivered by healthcare professionals within NHS Dumfries & Galloway is complex as its purpose is to ensure care is: person centred, safe and effective for every person, every time at the right time. The NHS D&G programme is called 'Care Assurance'.

The aims and objectives of the Care Assurance system are:

- To act as a means to ensure consistency in the delivery of high quality standards of care which has a positive impact on people who use the health care services in inpatient settings within Acute and Community Hospitals
- To reflect national and local priorities
- To identify and celebrate good practice and promote the dissemination of good practice throughout the organisation
- To identify areas of practice not meeting the locally agreed Standards and understand where this may be region wide
- To provide support to continuously improve, using knowledge and information gained from the Care Assurance Report for each area and across the region

Within NHS Dumfries and Galloway there are 3 Levels of assuring the care we provide as a health Board:

<u>Level 1 Care Assurance</u>:

Twice per week the Senior Charge Nurse (SCN) or Charge Nurse, along with a Registered Nurse (RN) or Health Care Support Worker (HCSW) will complete the Level 1 Care Assurance proforma for a person who is using inpatient/ward/ hospital services.

Level 2 Care Assurance:
Once per month the Nurse Manager for their area, along with an RN or HCSW, reviews and completes the Level 2 Care Assurance for one person using inpatient/ward/ hospital services.

Level 3 Care Assurance:
The Level 3 Care Assurance framework, assessed by the Excellence in Care Lead, is designed to complement and build upon the Level 1 and 2 Care Assurance processes. It will review the quality of care being provided based on the following National Standards: Care of Older People in Hospital (2015), Food Fluid and Nutrition (2014), Complex Nutritional Care (2015) and the Dementia Care Standards, along with the framework from Leading Better Care. The results of Level 3 undertaking are provided back to the local team and their managers. From this they undertake, with their team, an action plan for improvement which is then implemented and ongoing monitoring for improvement measured. This is also an ideal opportunity to celebrate with teams where areas' high standards are noted.

All Cottage Hospitals have now had full Level 3 reviews. The table below informs of current level of achievement.

Community Hospital	Current Status	KEY	
Castle Douglas	Working back towards bronze	Bronze	Each Standard achieves at least 75% compliance
Kirkcudbright	Working towards Bronze	Silver	Each Standard achieves at least 85% compliance
Newton Stewart	Silver		
Thornhill	Silver	Gold	Each Standard achieves at least 95% compliance
Annan Hosp	Working towards Bronze		
Thomas Hope	Working towards Bronze	Exemplary Award	3 consecutive Gold assessments achieved in succession
Lochmaben	Bronze		
Moffat	Silver		

4.3.2 Main Findings:

Two Cottage Hospitals have achieved Silver in their last Care Assurance level 3 reports. During the period of working towards this level of practice, both of these two Cottage Hospitals have been subject to capping of beds, either for short or long term periods. It is therefore worthy of noting the achievement and the link to having appropriate staffing for appropriate numbers and dependency of patients. The Directorate does not make light of this achievement but, in considering Safe Staffing and Excellence in Care together, it highlights the need for staff to have appropriate time and skill to achieve and provide high standards of care.

The last three Cottage Hospitals to be brought on stream to the process are still working towards Bronze Status. One cottage hospital, due to seeing a downward turn in their capacity and assessment compliance, has reduced from Bronze to

Working towards Bronze status. Notably this hospital has had a significant sustainability of medical provision. As reported last year, the Directorate had recognised the need to work closely with the Interventions for Dementia Education Assessment and Support (IDEAS) team to support training our multi professional clinicians to assess people's cognition and ensure that the relevant legislative records are in place i.e. AMT 4 and 4AT assessments with Section 47* documentation being completed by a medical officer where applicable.

The achievement noted in the cottage hospitals from 'working towards' and achieving Bronze and Silver can be partly attributed to this valuable input, input which has been part of "House of Care" work. Further work and progress has been undertaken by the lead nurse, the IDEAS team lead and the Dementia Nurse Consultant, with a Pathway being drawn up, along with a suite of assessment documents. This work is almost at the stage where it will be passed through governance processes for comment, suggestions and changes, before implementation.

Recording and completion of falls assessments remains inconsistent within the Directorate and across the Board area. This remains a priority area for the teams, and work to ensure consistency of approach is currently being considered by the Deputy Director of AHP's (Board Lead for Falls Strategy), along with the Lead Nurse. Falls are one of the top 3 adverse incidents reported within the Directorate.

4.3.3 Next Steps

The Excellence in Care Dashboard is now in use for inpatient areas, with further development ongoing through our NHS D&G lead. All Cottage Hospitals are linked to this work and it remains a high priority and focus for the Nurse Managers.

Also Community Adult General Nursing is now reviewing locally the indicators which could be utilised to measure the quality of care provided by their service.

4.4 Risk

The Directorate have been working to ensure that they are 'Connecting Quality' particularly in terms of Risk, Adverse Events and feedback. A new Risk and Quality Manager came into post in September 2018. Since coming into post, he has been actively working with the localities to be accountable and responsible for their risks, adverse events and feedback, assisting them to analyse and understand where improvement work is required at local and regional levels.

A Directorate 'Connecting Quality' meeting was last held in December 2018. An SBAR report and structure (Appendix 1) has since been submitted to the Directorate Senior Management Team which recommended a changed approach to Connecting Quality effectively led from the ground up as opposed to the top down. This is now being taken forward as an improvement project, working with localities to establish their revised approach to connecting quality with potentially different tests of change across the localities to help establish which models can provide the best input to the Connecting Quality Agenda.

The General Manager has a risk register logged and reviewed on the DATIX system. The top three risks (based on rating) identified are:

- Sustainability of the Out of Hours Service
- Sustainability of Primary Care Services
- Management of Forensic Medical Services

These three high level risks are being mitigated by work we are doing to meet the aims and outcomes of programmes such as Scottish Patient Safety Programme, Primary Care Transformation, GP Contract, District Nursing Reviews, ANP Development and Technology Enabled Care etc.

4.4.1 Sustainability of the Out of Hours Service

Challenges around the sustainability of the present Out of Hours (OOHs) delivery model have been acknowledged over the past few years. A risk graded very high, with a risk scoring of 20, is listed on the corporate risk register (ID 2314). While some small tests of change and variations to the model, including increasing remuneration to doctors, have been implemented, operational delivery of the service has remained a challenge. An internal audit report published in March 2018 gave a moderate assurance level. The service has been under considerable pressure from both sustainability and workforce perspective and remains under review.

In Dumfries and Galloway, the Health & Social Care Partnership has established an Unscheduled Care Steering Group comprising 7 work streams and chaired by the Chief Officer. The purpose of the group is to provide high level strategic oversight and ownership of the Unscheduled Care Programme and to join together the work of the 7 work streams to transform the delivery of unscheduled care across Dumfries and Galloway. One of the work streams chaired by the Chief Officer is focussing on considering alternative delivery models for sustainable OOHs provision within the umbrella of services providing unscheduled care. This group reports through to and provides assurance to the Unscheduled Care Programme Board.

As part of the review of OOHs service, we have agreement from the OOHs management team and representatives from the Emergency Department as to the guiding principle on which to base a proposed model for the delivery of a sustainable OOHs service. The aim is to provide an OOH model of care within the umbrella of unscheduled care that is equitable for patients, in addition to being affordable, and sustainable in the long term. The proposed model aligns with the following principles:

- Medical led MDT model with GP input as the expert medical generalist
- Development of Hub and Spoke MDT model
- Competency led deployment of the multi professional team

OOHs and the Emergency Department have both agreed that this is a complimentary way to develop the service and strengthen relationships.

In terms of the OOH service itself, a temporary investment in the administrative/management support to the service has stabilised its crucial

coordinating and support element. GP shift coverage remains unpredictable but is currently better than it has been throughout 2018. The administrative staffing is now at full complement and an interim service manager was appointed in August which has been underpinned by improved procedural guidance that sustains continuity.

Datix risks are regularly reviewed and reassessed in the light of changing circumstances and developments. Risks 2513 and 2588 relating to OOH's have reduced from high to medium level risks.

The OOHs review group met on 5 December 2018 and agreed the principles around future service models for the services based in Wigtownshire and also Dumfries & Galloway Royal Infirmary, covering the other 3 localities. Further improvement work is ongoing throughout 2019.

4.4.2 Sustainability of Primary Care Services

The situation surrounding GP colleagues both in our region and nationally are well known.

The Primary Care Transformation Programme Board was established in May 2018 to provide the role of strategic leadership, scrutiny and review for the Primary Care Transformation Programme.

A Primary Care Improvement Plan for Dumfries & Galloway has been developed in conjunction with the GP Sub Committee Executive Team. This outlined at a high level how new services will be introduced before April 2021, to enable the establishment of effective multi-disciplinary teams at practice and cluster level. This plan was approved by the IJB in July 2018. An updated version of the Primary Care Improvement Plan was presented to the IJB in April 2019 for approval.

The Primary Care Transformation Programme now has twelve workstreams which are looking collectively at the delivery of the 2018 General Medical Services Contract. The IJB will continue to receive regular updates throughout 2019.

4.4.3 Management of Forensic Medical Services

Following the formation of Police Scotland in 2013, there have been a number of changes which have had a direct knock on effect to the services delivered by Community Health & Social Care. The NHS has a responsibility to deliver care to persons held in Police Custody. Given challenges in delivering Out-of-Hours Services this has had led to new approaches in how we deliver some of this care delivery. In addition, improvement has been identified in how we support some very specific areas of the Forensic Medical Service, including potential victims of sexual offences.

The update on how we are managing this risk is as follows:

Dumfries Police Station

Dumfries Police Station is the main custody holding area for the Dumfries & Galloway Region. There are now Four Forensic Medical Examiners (FME), made

up from local GP's who work on a 1:4 on call rota. This is working well with no issues reported.

Wigtownshire

The present FME contract / service level agreement does not include cover to those in custody in Wigtownshire where the holding area is at Stranraer Police Station.

To support these patients and improve service delivery, we are progressing a number of actions to mitigate the risk that this presents to both Police Scotland and the Board. The actions are listed as follows:

- Telephone triage and initial advice provided by FME covering Dumfries Custody
- For health input the custodian needs to be taken to GCH for health interventions, taking police officers away from policing for what can be number of hours
- Physical health assessments currently provided by clinical staff at the Emergency Department of Galloway Community Hospital (fit to detain)
- Community Pharmacy offering training for custody officers re medication
- Supervised methadone consumption provided by nurses from the NHS Drug & Alcohol Service (Mon / Fri day time hours only)
- Progressing the role of community nurses in supporting custody for wound and infection management (Mon / Fri day time hours only)
- Pharmacy / Medication action plan in place
- OOH Doctors reminded of national guidance on the delivery of police custody healthcare and forensic medical services and the role they need to play

This is still continuing to make good headway with the Police Inspector - Custody Division advising in early April that Police Scotland feel progress was being made across a number of areas and felt the service was now as safe as it could be, given available resources and geography.

Forensic Update

A Forensic Suite will be situated at Mountainhall Treatment Centre adjacent to the Sexual Health Team. Progress is well under way for the physical build and our local estates team are working to a time line of handing over an operational centre by mid-May.
The location will have a discreet entrance and alternative access will be available for professionals via Sexual Health. The site is easily accessible by public transport and has onsite parking. The design will have the facility for interviews to take place in an environment that will be non clinical and will have a 'homely' feel. The space will be demographic neutral, with the facilities to turn into a child / adolescent space when required.

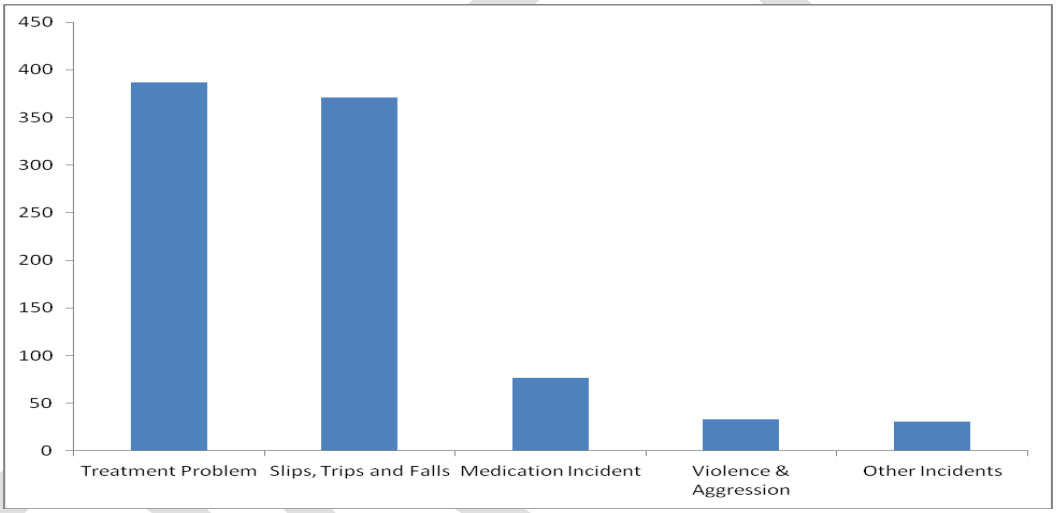
We are taking a partnership approach with Police Scotland, FME lead and local Rape Crisis in providing expertise and ensuring that the survivor is at the heart of what we do. The Chief Medical Officers Rape & Sexual Assault Taskforce are content with this arrangement, and have visited the site.

4.5 Adverse Events

1087 adverse events were reported from 1 April 2018 to 31 March 2019. Of these 497 were classified as near misses and resulted in no harm (Category 3), 585 resulted in temporary harm (Category 2), 5 were classified as potential significant adverse events (SAE) (Category 1).

Of the potential Category 1 incidents, three were not commissioned for SAE review and were returned to the Directorate for local investigation. The other two adverse events were followed up as Level 2 Reviews. One was a grade 4 pressure ulcer and learning was identified and shared with relevant teams. The other adverse event related led to improvement relating review to standard operating procedures relating to administration in the Diabetes Team.

The top five Adverse Event Themes are Treatment Problems; Slips, Trips and Falls, Medication Incidents; Violence & Aggression and Other Incidents



Within the **'Treatment Problem'** theme the highest number of incidents or events reported relate to Pressure Ulcer (PU) acquisition or development, a trend seen across the region. Regional work, led by the Deputy Director of Nursing, is ongoing in a local Pressure Ulcer Collaborative which is now supported by the recently appointed Tissue Viability Nurse. In addition a new process is in place where in certain cases, particularly the development of Grade 3 & 4 pressure ulcers, an Adult Support and Protection referral is requested.

Other incidents covers a number of other issues classed under "non-clinical equipment" and "transport" and is predominately used to identify issues which are otherwise not categorised within Datix.

4.5.1 Medication Administration

There are two main themes identified within medication errors: Medication Administration and Dispensing.

Pharmacy

Patient Safety has been a key component of the Prescribing Support Team's prescribing improvement plans for many years. In 2018/19 there was a move to make safe prescribing the onus of the Prescribing Local Enhanced Services (LES) which has traditionally been used to drive cost-effective prescribing. This year, practices were given options to work on safety and clinical effectiveness in relation to prescribing in the following areas:-

- Antibiotic prescribing
- HRT
- Diabetes
- DMARDs
- Respiratory
- Anticholinergics

This will be a 3 year rolling programme where practices will choose 3 options each year, one of which must be in line with the National Prescribing Strategies on respiratory, diabetes and pain. This work is supported by the Prescribing Support Team.

Further to the work that is ongoing with the Prescribing LES, we also regularly review the National Therapeutic Indicators available on PRISMS. This gives us information on D&G performance versus a suite of key evidence based quality and safety indicators.

At present a prescribing improvement matrix is being developed which will consist of a number of Key performance indicators (KPI's), several of which will be focussed on clinical effectiveness and safety. This will be used to form discussion with General and Locality Management on prescribing performance to guide improvement.

Administration of Medicines

It was noted during review and probing of data in 2018 that Insulin Administration was accounting for 30% of all medical administration errors reported. The majority of those reported were at home. A sub group of the Medicines Administration Group was established in December 2018. This group is chaired by one of the Diabetic Specialist Nurses, supported on the group by active members from medical, nursing and improvement services. The group will report directly to the Medicines Administration Group. To date they have undertaken an Insulin Failure Mode and Effect Analysis from Datix data. They have agreed their terms of reference, completed their project charter and have begun to work on change ideas. This is demonstrated below in their driver diagram. The Lead Nurse from the directorate is acting as Improvement Coach to the chair of this group.

General Practice Clinical Pharmacy Team Support to Primary Care

We are in the early phase of implementing a pharmacotherapy service in line with Transforming Primary Care programme. This service puts more pharmacists and pharmacy technicians on the front line in GP practices to deal with medication issues arising on a daily basis in practices and also to carry out targeted medication reviews. Our stated long term aim of this service is "By April 2021, every GP

Practice will benefit from a viable, well supported pharmacy workforce that are able to flourish and deliver a service that helps to sustain GP practices and improves quality care for patients".

HEPMA

Challenges exist in relation to HEPMA and other systems at community hospitals. The IT team report that network links are currently not capable of supporting such services and the network links are not resilient; therefore subject to total failure.

This remains a regular point for discussion during updates from IT Senior Management at the Community Health & Social Care Senior Management Team.

4.5.2 Slips, Trips and Falls

Falls Bundle & Collaborative

It is acknowledged that the numbers of falls by patients remains to be in the top 3 Adverse Incidents. This can also be linked to the Care Assurance work described in Section 4.

Care Assurance reports are telling us that teams have low compliance in ensuring that all patients in cottage hospitals have robust care plans in place for the Multi Disciplinary Teams to follow. The assessment of all patients for risk of falling when transferred or admitted to a cottage hospital has improved this year.

With ongoing training and feedback during the supervision elements of Care Assurance, we aim to improve the planning and implementation of interventions and treatments to reduce the number of falls and/ or reduce the harm occurring from falls. This is along with the roll out of a consistent approach to assessment of falls and appropriate care planning across NHS D&G.

4.5.3 Violence and Aggression

Nearly all of these incidents relate to patients who are cognitively impaired and not necessarily fully cognisant with or aware of the potential of their actions. Unfortunately on some occasions the outcomes have led to harm to staff.

These are difficult situations to deal with and support is normally requested from colleagues in Mental Health and other departments to manage these patients most appropriately, also with input from families.

The Board's Conflict Resolution Manager has completed Dementia Champion training which is helping design multi-team approaches to managing patients who are cognitively impaired.

4.5.4 Learning Summaries

The Community Health & Social Care Directorate has made good use of Learning Summaries in recent months to share key derived from learning resulting from adverse events with staff.

See Appendix 2 - Example of Learning Summary

4.5.5 Datix – Social Work

An ongoing challenge is the inability, due to working on different base systems, for Social Work colleagues to report on the Datix system. This is reliant on NHS staff to report on their behalf and is a key area for improvement. Work is ongoing with colleagues in IT to identify how this can worked around.

4.6 Feedback

The Directorate received 86 items of feedback during the period 1 April 2019 to 31 March 2019; these are broken down as follows:

Type	Number
Stage 1 Complaint	12
Stage 2 Complaint	17
Informal Concern	20
Patient Services Enquiries / Comments	11
Compliments (recorded on Datix)	26

As can be seen above, 80% of feedback was either complimentary or was dealt with informally, 20% was dealt with via the formal stage 2 process.

Of the 17 Stage 2 Complaints, 6 were fully upheld. 100% were responded to in 20 working days or had agreed extensions in place.

There were no complaints followed up on by the Scottish Public Services Ombudsman which we have received feedback in relation to. One matter is currently being looked at by the SPSO and we expect feedback regarding this is February / March 2019.

The Risk & Quality Manager is supporting the localities as a point of contact for advice on operational feedback management and supporting this via the Connecting Quality Group.

The above compliments section refers only to those recorded on the Datix system and does not reflect the full number of compliments received in cards or verbally etc. The Risk & Quality Manager will be working closely with the Patient Feedback Manager throughout the coming year to devise tests of change which can be trialled in areas of the CH&SC Directorate to improve the collation and recording of positive feedback.

<u>Joint Complaints / Social Work Process</u>

Social Work specific complaints are led by the relevant department. Both NHS and Social Services follow the same national Complaints Handling Process and standards. Where complaints relate to a range of services in the IJB, these are normally overseen by Locality Management. A process (Appendix 3) is in place to

assist identifying the pathway for complaints in CH&SC. The main points of note are:

- The Complaints Handling Procedure encourages a joint approach and response to complaints where possible.
- When a complaint comes in that spans more than one organisation, we seek consent to share it with the other organisation/s named.
- On receipt of that consent we have a discussion with the other organisation/s to agree who will lead on the investigation and response. The other organisations send their contributions to the lead organisation to include with their reply.
- There is scope to improve how we share learning and this is currently being discussed both locally and nationally with a view to improving.

4.7 Other Improvement work to Improve Safety and Reduce Harm

4.7.1 Advanced Practitioners in Community Health & Social Care

The role out of and increased use of Advanced Practitioners (AP) in Community Health & Social Care continues, with both permanent and Trainee AP's featuring increasingly across Primary and Community Care in Dumfries & Galloway. This allows more appropriate care delivery from a range of practitioners and supports better focus on specific patients by other colleagues, General Practitioner Doctors being an example.

4.7.2 Technology Enabled Care / Information Technology

Improvement in the use of Technology across Community Health and Social Care is integral to the reduction of risk to patients and staff by using IT to access and share information and participate in real time communication.

NHS Attend Anywhere enables people to access services through video rather than face to face where appropriate. The system uses everyday technology like tablets and smart phones and has been designed to be accessible from people's homes as well as from Health and Social care facilities. The past year has seen Speech and Language Therapy, Psychology and Respiratory offer appointments through NHS Attend Anywhere and uptake is beginning in Primary Care. A significant development to "scale-up" the use of NHS Attend Anywhere within Acute outpatients and increasing the use with local care homes (both funded by the National TEC Programme) will take place during 2019 and will facilitate the development of services offering NHS Attend Anywhere appointments.

Home and Mobile Health Monitoring using the Florence text message system enables people to be self-manage their condition by receiving text messages from services. It is also possible for people to be prompted to send in readings using Florence and teams can be notified of readings which may need further investigation. A good example of this is using Florence for Blood Pressure monitoring although this is not current offered in D&G. Live services include medication reminders (in Wigtownshire through Community Pharmacy and mPower), Smoking Cessation and Podiatry. The majority of our live protocols focus

on the drip feed of information to people for them to self manage and be aware of when they may need to contact us for support

The Telecare service in the region continues to grow and now supports over 3,700 people – an increase of 10% in the last two years. We have been working to improve people's awareness of the service including the provision of Telecare Awareness training to staff across the HSCP so that they are confident talking about Telecare to people and referring into the service. There has been engagement with a local Care Home in Nithsdale and Langholm Community Hospital to see how Telecare can support staff to keep residents and patients safe and demonstrate how the service could support them to live independently when they return home. The Activities of Daily Living (ADL) Suite at DGRI has had Telecare and Sensory Support equipment installed within it so that people that are being discharged from DGRI can see how the equipment can keep them safe and independent at home. The ADL Suite will also be open to individuals across the Health and Social Care Partnership to find out more about the support on offer in people's homes.

Loreburn Housing have been having great success introducing a system called ARMED that involves wearable's ie smart scales and strength grips to alert people that they may be at risk of falling. The system also encourages people to stay hydrated and active during the day. It was introduced at a sheltered tenancy block in Dumfries and since its introduction there have been no falls by participating residents and is being rolled out to other tenancies across the region.

4.7.3 Business Continuity Planning

The Community Health & Social Care has a number of potential challenges in respect of business continuity. Business continuity incidents can arise from a range of circumstances, including failures in infrastructure leading to loss of a facility through to adverse weather reducing the ability of staff to reach patients in the community.

A root and branch review of all business continuity (BC) arrangements in the CH&SC directorate has been undertaken since September 2018. A new over-riding BC management structure based on the well-recognised "Strategic, Tactical, and Operational Command" hierarchy is in place with action cards for key managers. The Senior Management Team is confident that these arrangements would go a long way to successfully managing any situation that arose.

Notwithstanding the Management Structure, it is still essential that BC plans are in place for critical services and facilities throughout the localities. All local plans have been reviewed to confirm their fitness for purpose. These are now being amended and updated to ensure they are fit for purpose with future review in 2021. As these are being updated they are being uploaded to Beacon for easy access if required. Three of the localities are now fully uploaded to Beacon with one ongoing.

An exercise of BC arrangements for the Directorate, held in November 2018, was successful and confirmed the Directorate's ability to respond to a BC incident. The exercise was based on a severe weather scenario which either directly affected or required mutual aid from each of the localities. This was timeous in identifying

learning points which were shared with the Winter Planning Group, chaired by the Chief Operating Officer. These learning points were quickly actioned and completed.

Going forward the localities all plan small scale exercises throughout the coming year. A further Directorate wide exercise will be delivered in early autumn 2019.

4.7.4 Lone Working

As a direct outcome of the above Business Continuity Exercise, teams had discussion around arrangements for safeguarding lone workers in the community. It is a necessity, to deliver suitable social and health care in the community setting, that staff are required to work alone.

It was identified that Dumfries & Galloway Council colleagues have access to a lone worker monitoring system which forms part of Carecall. Community Health & Social Care staff from two localities are now involved in progression of a pilot of use of this system.

More information regarding the lone working system and how it operates can be found via https://youtu.be/r0bcyepIHl0 which links to an instructional video completed by CH&SC and Dumfries & Galloway Council staff.

4.7.5 Health & Safety Walkrounds

Joint Health & Safety walk rounds are being undertaken across all four localities during spring 2019 with the Board Health & Safety Advisor and Directorate Risk & Quality Improvement Manager. So far, three Community Hospitals have been visited and inspected. The results in these areas were overwhelmingly positive with good adherence to health and safety requirements and evidence of strong understanding of this by staff.

4.7.6 Fire & Security

The Estates and Facilities Directorate have appointed Dominic Smith to a new role encompassing Fire Safety & Security. Fire Safety audits of all CH&SC facilities will be completed by the end of March 2019 and reports provided back to Directorate Senior Management Team.

Joint walk rounds with the Risk & Quality Improvement Manager to review security will be undertaken and reported on during early summer 2019.

SECTION 2: COMPLIANCE WITH GOVERNANCE STANDARDS

5. Resource Implications

5.1. The management of the daily operational risks can be managed within existing resources. Scottish Government is supporting the implementation of the GP contract/Primary Care Transformation.
Resources may be required in respect of the OOH services and to support IT infrastructure but at this juncture figures are not known

6. Impact on Integration Joint Board Outcomes, Priorities and Policy

6.1. The Community Health & Social Care Directorate play a central role in the delivery of the nine National Health & Wellbeing outcomes and are responsible for the delivery of the four locality plans.

7. Legal & Risk Implications

7.1. As per section 4.4.3 please see the updates with regard to Management of Forensic Services and the Board's duty to support.

There is significant risk attached to the Out of Hours Service in the short/medium term

8. Consultation

8.1. General Manager - Community Health & Social Care
Risk & Quality Improvement Manager
Lead Nurse - Community Health & Social Care
Lead Pharmacist - Community Health & Social Care
Principal Manager- Reablement and Support
Patient Feedback Manager - Patient Services

9. Equality and Human Rights Impact Assessment

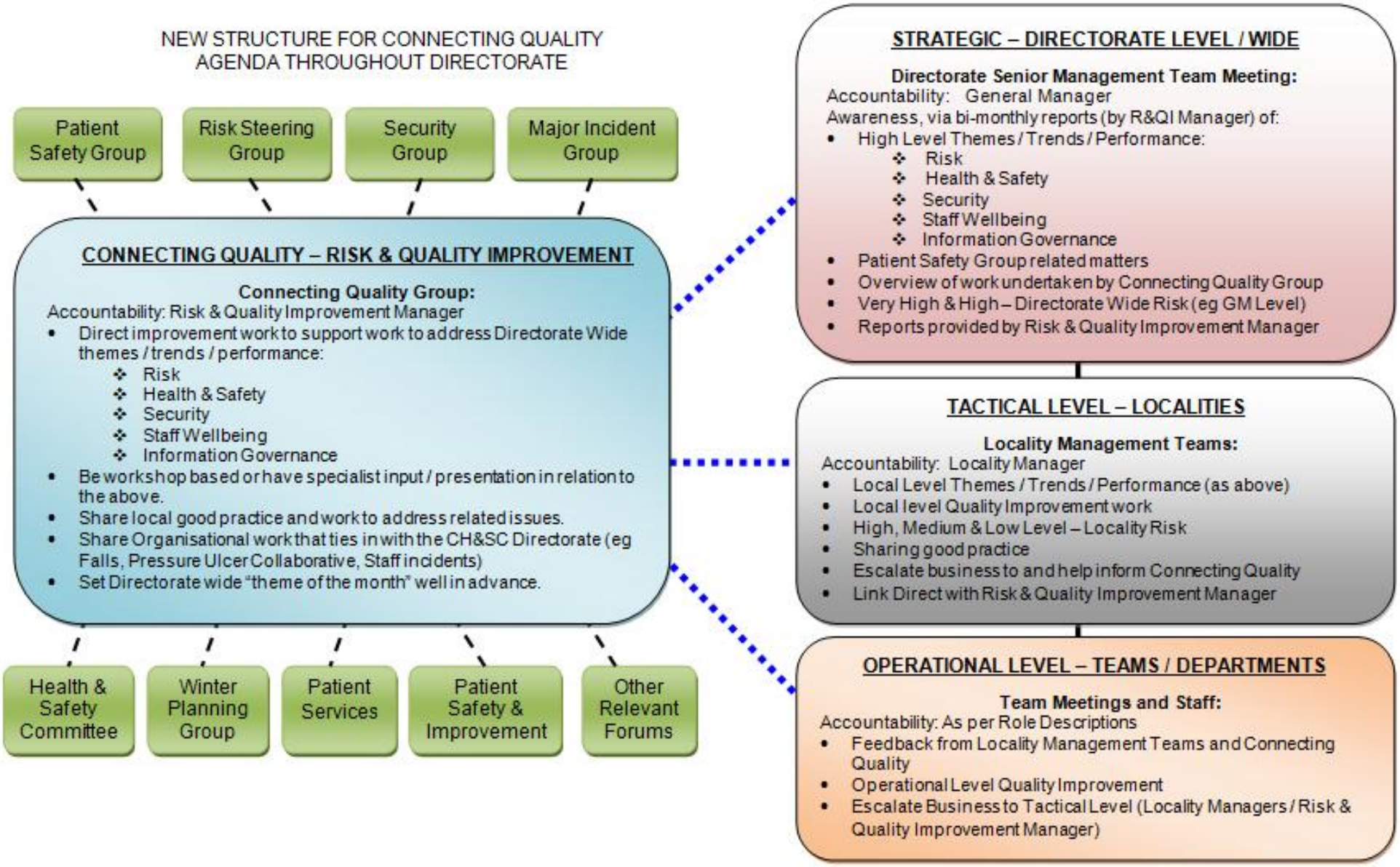
9.1. Not Applicable.

10. Glossary

10.1.

CHSC	**Community Health & Social Care Directorate**
CASS	**Care and Support Service**
STARS	**Short Term Assessment and Reablement Service**
OOH	**Out of Hours**
AHP	**Allied Health Professionals**
HCPC	**Health and Care Professionals Council**
NMC	**Nursing and Midwifery Council**
SSSC	**Scottish Social Services Council**
GMC	**General Medical Council**
HIS	**Healthcare Improvement Scotland**
HEI	**Healthcare Environment Inspectorate**
SHC	**Scottish Health Council**
SIGN	**Scottish Intercollegiate Guidelines Network**
SPSP	**Scottish Patient Safety Programme**
KPI	**Key Performance Indicators**
loRN	**Indicator of Relevant Need**
JiT	**Joint Improvement Team**
eKSF	**electronic Knowledge Skills Framework**
CPR	**Cardiopulmonary Resuscitation**
CPD	**Continued Professional Development**
EIC	**Excellence in Care**
SEND	**Scottish Executive Nurse Directors**
RN	**Registered Nurse**
HCSW	**Health Care Support Worker**
IDEAS	**Interventions for Dementia Education Assessment and Support**
CNO	**Chief Nursing Officer**
TNMaHP	**Transforming Nursing Midwifery and Allied Health Professional**
NMaHP	**Nursing Midwifery and Allied Health Professional**
IT	**Information Technology**
PDSA	**Plan Do Study Act**
HSC	**Health and Social Care**
AFC	**Agenda for Change**
GCH	**Galloway Community Hospital**
MDT	**Multi Disciplinary Team**
POA	**Power of Attorney**
PU	**Pressure Ulcer**
SAER	**Significant Adverse Events Review**
SPSO	**Scottish Public Services Ombudsman**
DDD	**Daily Dynamic Discharge**
AI	**Adverse Incident**
RAQIM	**Risk & Quality Improvement Manager**

Appendix 1 –


NEW STRUCTURE FOR CONNECTING QUALITY AGENDA THROUGHOUT DIRECTORATE
Patient Safety Group
Risk Steering Group
Security Group
Major Incident Group
CONNECTING QUALITY – RISK & QUALITY IMPROVEMENT
Connecting Quality Group:
Accountability: Risk & Quality Improvement Manager
Direct improvement work to support work to address Directorate Wide themes / trends / performance:
Risk
Health & Safety
Security
Staff Wellbeing
Information Governance
Be workshop based or have specialist input / presentation in relation to the above.
Share local good practice and work to address related issues.
Share Organisational work that ties in with the CH&SC Directorate (eg Falls, Pressure Ulcer Collaborative, Staff incidents)
Set Directorate wide "theme of the month" well in advance.
Health & Safety Committee
Winter Planning Group
Patient Services
Patient Safety & Improvement
Other Relevant Forums
STRATEGIC – DIRECTORATE LEVEL / WIDE
Directorate Senior Management Team Meeting:
Accountability: General Manager
Awareness, via bi-monthly reports (by R&QI Manager) of:
High Level Themes / Trends / Performance:
Risk
Health & Safety
Security
Staff Wellbeing
Information Governance
Patient Safety Group related matters
Overview of work undertaken by Connecting Quality Group
Very High & High – Directorate Wide Risk (eg GM Level)
Reports provided by Risk & Quality Improvement Manager
TACTICAL LEVEL – LOCALITIES
Locality Management Teams:
Accountability: Locality Manager
Local Level Themes / Trends / Performance (as above)
Local level Quality Improvement work
High, Medium & Low Level – Locality Risk
Sharing good practice
Escalate business to and help inform Connecting Quality
Link Direct with Risk & Quality Improvement Manager
OPERATIONAL LEVEL – TEAMS / DEPARTMENTS
Team Meetings and Staff:
Accountability: As per Role Descriptions
Feedback from Locality Management Teams and Connecting Quality
Operational Level Quality Improvement
Escalate Business to Tactical Level (Locality Managers / Risk & Quality Improvement Manager)

Appendix 2 – Example of Learning Summay

Sharing Learning Points

LOCALLY

Subject: Home visits – Venepuncture / Bloods

Category: Adverse Event Themes Learning

Preventing: Repetition & Harm

Key words: Improvement, Prevention, Process, Procedure, Verification, Consent

Date issued: January 2019

What happened?

On two occasions recently it has been reported that staff have attended the homes of patients and performed venepuncture following requests by GP practice. It has quickly been established that verification of whether staff have attended the correct address, and have the right person, has not occurred and blood has on these occasions been taken from the wrong person.

What went well?

- On realising the mistake that has occurred staff have reported this to senior colleagues and it has been submitted on Datix to allow lessons to be learned action taken and the lessons and outcomes to be shared to assist in prevention of repetition.
- The patients, or their families, who had blood taken inadvertently have been visited and the nature of the adverse event that has occurred explained in line with Duty of Candour.

What could we improve?

- Where a cognitive impairment exists and a potential power of attorney/guardianship is in place we need to be mindful of the patient data being provided in cases of "one off bloods" where patient isn't on the team caseload, to ensure that the necessary basic information is passed to staff, i.e. "has a cognitive impairment."
- Exploring if there is capacity to show the patient's address on the printed label which is attached to the blood request form. This would allow staff to check full details and in this case would have prevented the error from going ahead.
- **All staff throughout the Community Health & Social Care Directorate involved in performing Venepuncture to re-familiarise themselves with "Chapter 10.1 – Venepuncture" of the Royal Marsden Manual https://www.rmmonline.co.uk/manual/c10-fea-0051, by end of February 2019, with particular emphasis on point 4 of the Pre-procedure actions.**

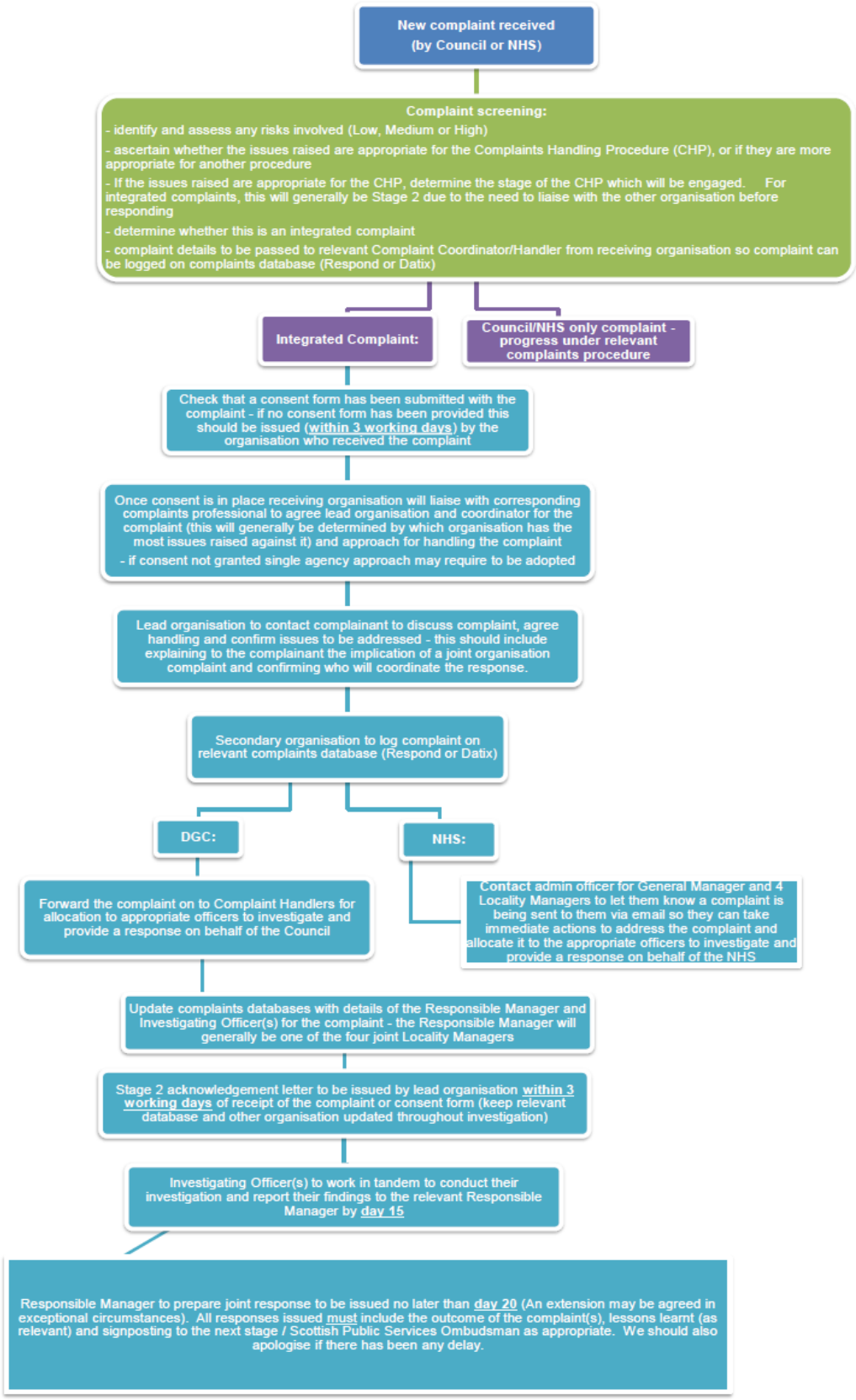
What have we learnt?

All staff, prior to performing procedures MUST, as per the Royal Marsden Manual:
Check that the identity of the patient matches the details on the request form by asking for their full name and date of birth and checking their identification.

If the patient is unable to communicate, clarity may need to be gained with a relative/carer or registered healthcare professional to whom the patient is known.

There is need for a safe referral / information system for MDT use in Primary Care.

Appendix 3 – Complaints Handling Process



Dumfries and Galloway Integration Joint Board

DIRECTION

(ISSUED UNDER SECTIONS 26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014)

1.	Title of Direction and Reference Number	
2.	Date Direction Issued by Integration Joint Board	
3.	Date from which Direction takes effect	
4.	Direction to	
5.	Does this direction supersede, amend or cancel a previous Direction? If yes, include the reference number(s)	
6.	Functions covered by Direction	
7.	Full text of Direction	
8.	Budget allocated by Integration Joint Board to carry out Direction	
9.	Desired Outcomes	
10.	Performance Monitoring Arrangements	
11.	Date Direction will be Reviewed	