AGENDA ITEM No.9

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership	Integration Joint Board
Held on	25 September 2019
Agenda Item	9
Title	Clinical and Care Governance Annual Report 2018 - 2019

Summary

The Clinical and Care Governance Annual Report 2018 – 2019 reflects on the clinical and care governance arrangements of the HSCP and the progress made in improving the quality of clinical care. The report is structured around the three main domains set out in the National Quality Strategy; Safe, Effective, and Person-Centred Care.

The report describes the main governance framework and demonstrates our work to improve the quality of care within the partnership.

The report was approved by the Clinical and Care Governance Group on 5 June 2019.

Presented by	Deirdre McCormick, Chief Nurse

Action Required

The Integration Joint Board are asked to:-

- note the Clinical and Care Governance Annual Report 2018 -2019
- note that the IJB will retain oversight of the role and function of the Clinical and Care Governance Group where clinical and care governance will be taken forward

Implications checklist – check box if applicable and include detail in report

☐ Finance	☐ Policy	☐ Legal	☐ Equalities
☐ Risk	☐ Staffing	☐ Directions	☐ Infrastructure

East Renfrewshire Health and Social Care Partnership

Annual Clinical & Care Governance Report 2018 - 2019

1. Introduction

1.1 East Renfrewshire Health and Social Care Partnership was formed in 2015 and covers the population within the same geographical boundary as East Renfrewshire Council.

1.2 East Renfrewshire Health & Social Care Partnership (HSCP) has an estimated total population of 95,238.

1.3 Each year an annual report reflecting on the clinical governance arrangements of the Health & Social Care Partnership and the progress it has made in improving the quality of clinical care is produced. The report is structured around the three main domains set out in the National Quality Strategy: Safe, Effective, and Person-Centred Care. This report will describe the main governance framework and demonstrate our work to improve the quality of care in our Health & Social Care Partnership through a small selection of the activities and interventions. It is important to note that there is substantially more activity at personal, team, and service level arising from our collective commitment to provide a quality of care we can be proud of. This report can only reflect a small selection so is illustrative rather than comprehensive.

1.4 The Terms of Reference, structure, content and attendance to the (formerly) Clinical and Care Governance Committee, now Clinical and Care Governance Group, have been updated as a result of several workshops where key stakeholders had the opportunity to share ideas and discuss priorities. The change from formal committee status to informal group status is intended to facilitate open, honest discussion on sensitive matters.

1.5 A Clinical and Care Governance Facilitator has been appointed to help shape the Clinical & Care Governance Group process for East Renfrewshire. The post holder commenced post in December 2018 and will work in a shared arrangement with Inverclyde Health & Social Care Partnership.

2. Person-centred care

2.1 As at June 2018, 9 of the 15 GP Practices had access to a Community Link Worker, a pilot devised in conjunction with Recovery Across Mental Health (RAMH). The development is a partnership primarily between RAMH and East Renfrewshire Health & Social Care Partnership in response to a shared awareness of the impact on General Practice of a significant cohort of patients who sought recurring and regular support from GPs. The support required were often associated with loneliness, social isolation, lack of community connectedness and associated social issues, for example, housing, physical inactivity and financial issues. Patients are able to work with the Link Worker to identify the best services to suit their particular needs.

2.2 Feedback on the Link Workers has been extremely positive leading to improved outcomes for individuals, increased knowledge of community resources across primary care and a reduction in GP appointments for much of this cohort. As a result of the successful pilot, and using the Primary Care Improvement Fund in line with the Primary Care Improvement Plan (new GP Contract), the service has expanded to include all 15 practices, with an uplift in service in some practices who were involved in the pilot. Feedback remains positive.

2.3 East Renfrewshire has led for Greater Glasgow and Clyde on the development of Anticipatory Care Planning (ACP) via the use of Key Information Summaries (KIS). Good ACP has been repeatedly shown to reduce deaths in hospital in the final year of life and conversely to increase the rates of patients dying at home or in a hospice as per patient's wishes. It also reduces unwanted unscheduled admissions.

2.4 The following steps have been taken to improve uptake of ACP/KIS in East Renfrewshire:

- The paperwork used for ACP was simplified and re-ordered to match the on-screen order of KIS software
- The updated paperwork was reviewed at Clinical Senate and agreed to be shared amongst all NHS Greater Glasgow and Clyde Primary Care, for the use of GPs, District Nurses and Care Home Nurses
- The paperwork was shared to all GPs in NHS Greater Glasgow and Clyde along with a guide to successful completion of KIS so that the information is useful to not just GPs but also SAS and Acute medics (after advice from secondary care clinical directors on content)
- Subsequently the paperwork was further updated to an electronic version (fillable PDF) to enable paper-free completion of ACP
- A patient/carer information video about KIS was created to be shared on social media and shown in waiting rooms. This was approved by NHS Greater Glasgow and Clyde communications department and has also been shared on social media by the Prince & Princess of Wales Hospice
- Work is underway to create on Portal an electronic version of the paperwork so that consultants can create an ACP in the exact KIS format to be sent to GPs via EDT. Practice administrative staff can then transcribe the information to create a KIS, which remains the national platform for information sharing. Audit will be undertaken to assess increased use of KIS following these measures

2.5 In addition to the work already mentioned there are other areas of efficiencies to be highlighted

- 13 of our 15 practices have pharmacotherapy input of at least 0.4 WTE which is not matched by any other Health & Social Care Partnership
- At the end of last year 100% of GP Practices had agreed to use HMHM for hypertension management. So far all but 2 practices have recruited patients to the service. Over 640 patients have benefitted from the service with an estimation of over 1800 face to face appointments saved
- Advanced Practice Physiotherapists as the first point of contact has evidenced a direct release of GP time and streamlining of the patient journey. During March – April 465 appointments were available with 92% uptake
- Community Health Care Support Workers are in every practice providing phlebotomy, B12, BP and new patient registration

2.6 A Tier 2 service for Children and Families has been piloted in 2 practices, one in each locality. The aim of this service is to fill the long-term service gap in CAMHS for children and adolescents not meeting the Tier 3 criteria. The Family Wellbeing Service approach can be summed up as follows:

- Ensure that children's presenting needs are held within the context of family and community
- Effectively and honestly engage with parents, children and young people to fully understand the stories behind the presenting symptoms

- Ensure prompt early help is offered to improve the emotional wellbeing of children and families
- Prevent unnecessary referrals to specialist clinical services
- Improve the connection, relationships and resilience of families

2.7 One of the pilot practices completed an audit of the first 50 children they had referred. They had collectively required 45 GP appointments in the year prior to referral and only 8 in the year after referral, so a reduction in GP activity was clearly evident.

2.8 This evidence of appropriate use of the service and reduction in suboptimal use of GP appointments for family issues was taken to the Robertson Trust, to seek funding support to roll out the service to all 15 practices. They have committed to £1.2m over three years, the largest commitment ever made by the charity. This will extend the service to all 15 practices and represents a huge achievement in family-centred care for East Renfrewshire Health & Social Care Partnership.

2.9 All 15 practices in the area take part in the quarterly return of practice complaints to the board. The practices have added the learning gained to their submissions. This reflects both a recognition that sometimes the processes in GP practices fall down but also a willingness to apologise and use good communication to try and resolve patient concerns. We will monitor the quarterly returns to ensure the recommended changes have been put in place.

2.10 Only one complaint during the year was escalated to the SPSO; no further action was taken as the SPSO concluded that the practice involved had already taken all necessary actions.

2.11 It is recognised that there is a greater risk of harm from medicines when patients move between care settings. A care bundle was developed as part of the Scottish Patient Safety in Primary Care Programme as a result. The Medication Support Service is a pharmacy technician-led service which provides a comprehensive medicines reconciliation for patients discharged from hospital and who receive a homecare package. Following completion of the medicines reconciliation, the technicians contact patients to ensure that any changes are fully understood and when appropriate undertake home visits providing a person centred assessment of how they manage their medicines at home. Following assessment, tailored support is offered where required to help patients to take their medicines safely and effectively. The service also accepts referrals from any health or social care staff members to provide support and education on practical aspects of medicines use including compliance.

2.12 During 2018-19 the service has been running with reduced staffing capacity due to maternity leave. The service continued to support identified patients struggling with their medication at home responding to 788 patient referrals during 2018. The service staff also continued to provide a training programme for East Renfrewshire Carers on the safe administration of medicines.

2.13 The service has worked very closely with the East Renfrewshire Homecare Service. During 2018-19, 49 East Renfrewshire carers completed the safe administration of medicines training.

2.14 21 polypharmacy reviews were completed in one practice by a Prescribing Support Pharmacist. Medication was rationalised which resulted in an overall decrease in tablet burden for many patients and the de-prescribing of 21 items. Using the 7-step polypharmacy tool patients were able to voice their priorities and concerns, and make joint decisions about their medication.

2.15 In another practice with a large number of patients using compliance aids, medication reviews were undertaken by the practice pharmacists with these patients. Many of these patients were housebound, frail elderly. 159 of 201 patients were reviewed. The review process has included monitoring of bloods and helping patients understand their medicines better. Some patients had changes made to their medication such as reducing blood pressure or angina medicines to reduce the risk of falls from low blood pressure.

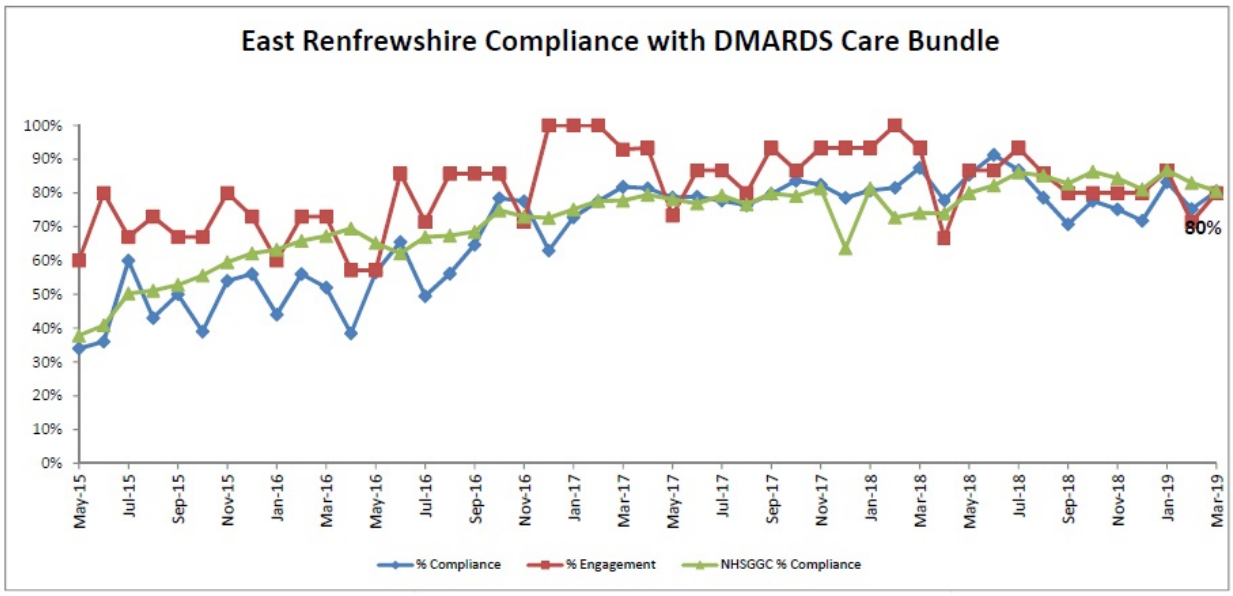
3 Patient Safety

3.1 All 15 practices participated in the final year of the DMARDs LES. The line chart below details the compliance with the DMARDS Care Bundle for East Renfrewshire and NHS Greater Glasgow and Clyde overall to the end of Year 4.

3.2 East Renfrewshire's performance has slipped since last year, at which point the Health & Social Care Partnership was doing the best in NHS Greater Glasgow and Clyde for compliance and engagement. Looking at the median data for the 4 year term, our final scores were 76% Compliance (NHS Greater Glasgow and Clyde 82%) and 80% Engagement (NHS Greater Glasgow and Clyde 81%).

3.3 The line graph below shows the trend over 4 years; we are performing better than at the start, but not as well as we have done at our best. Overall the rates on NHS Greater Glasgow and Clyde have risen to match where we are now.

3.4 The recent downtrend has been highlighted to the GP Forum and may be audited at cluster level.



3.5 An audit of work undertaken on behalf of secondary care, typically follow up blood samples post-discharge, demonstrated a need for a community phlebotomy service. The first appointees of the new PCIP were Healthcare Assistants, with each of the 15 practices having access to this service. The service includes domiciliary phlebotomy, meaning that patients have reliable access to safety checks post-discharge for the first time, as East Renfrewshire has not historically had a community phlebotomy service.

3.6 Care Home Medication Reviews - One Prescribing Support Pharmacist had a dedicated day each week to provide medication reviews to local care homes' residents. Reviews of East Renfrewshire residents in one care home were completed within 2018/19. Pharmaceutical Care Plans were created for 33 residents and 82 interventions were achieved. Common interventions include the de-prescribing of medicine unlikely to be of ongoing benefit or no longer required such as statins, analgesics, iron, folic acid, and thiamine. Patient safety issues addressed included stopping the inappropriate prescribing of prednisolone, repeated prescribing of the same antibiotic in urine infections, and referral of a patient for Parkinson's review. Other medication interventions included addressing inappropriate prescribing of medications and doses to reduce risk of adverse effects. Residents (and Powers of Attorney) were involved in the review process regarding their choices and preferences and these were acknowledged and acted upon such as dislike of 'cold' lidocaine patches and request to reduce strength of pain medication.

3.7 Pharmacy Falls Referrals – 33 patients were referred to the prescribing support pharmacists for a polypharmacy medication review. Medication reviews of patients after falling lead to improved patient safety. Polypharmacy is an independent risk factor for falling - all prescribed and purchased medication is checked to confirm that it is still indicated, prescribed at an appropriate dose, and being taken correctly by the patient, and any issues identified are addressed e.g. recommendation to stop/switch a medicine, use decision aid to improve compliance, change medication to a more suitable formulation.

3.8 An audit was undertaken in one GP practice by a Prescribing Support Pharmacist on prescribing of high dose Proton Pump Inhibitors (PPIs). The purpose of the audit was to reduce the frequency and intensity of prescribing as evidence has shown that long-term use of treatment doses of these medicines may increase the risk of bone fractures, *C.difficile* infection and vitamin B12 deficiency to name a few adverse effects. This audit was prompted by information from within NHS Greater Glasgow and Clyde that a high proportion of patients diagnosed with *C.difficile* had been on a PPI. Of 176 patients reviewed, 45 reduced dose and 28 stopped treatment.

3.9 The Medicines and Healthcare Regulatory Authority issued a warning in November 2018 about the risk of melanoma associated with medicines containing Hydroxychlorothiazide particularly with long-term use. The Prescribing team identified East Renfrewshire patients on this drug and ensured that patients were made aware of the need for checking skin lesions and moles for changes. Patients with a history of skin cancer were reviewed and had the drug discontinued where appropriate.

3.10 One of the areas of prescribing being targeted within 18/19 was long-term prescribing of high strength opioid medicines. These medicines lack evidence of benefit when used long term for chronic non cancer pain and have an increased risk of side effects. They are high risk drugs due to their potential for addiction and dependence also. Reviews of relevant patients on these medicines was undertaken in all practices supported by the prescribing support team with the aim to reduce doses to reduce the risk of adverse effects and improve patient safety.

3.11 The professional nursing assurance framework and associated work plan forms the basis of the Senior Nurse Leaders meeting within the partnership. The framework is based on the national nursing and midwifery professional framework developed on behalf of the Scottish Executive Nurse Directors (SEND) with local interpretation to show local assurance systems which are in place and being monitored.

3.12 The framework enables an iterative approach to quality improvement activity across all services. The District Nursing service was a targeted service for improvement in response to concerns raised by Unison on behalf of their members working within the service. A review of the service was commissioned by East Renfrewshire Health & Social Care Partnership Senior Management Team. The timeline for the review was from September 2016 – June 2018.

3.13 The review found that despite best intentions the operational and professional leadership within the service failed to provide the level of support required for front line staff. This had an impact on the quality of care patients received. Nineteen recommendations are presented under four key headings: Workforce Issues, System/Operational Issues; Continual Professional Development and Practice Issues.

3.14 Many improvements have since taken place within the service to address a range of issues which have been identified. Whilst staff morale and team working within the service has greatly improved there is more work to do. Based on the recommendations an improvement plan has been developed with progress being reported locally and to the clinical and care governance group.

3.15 The achievements made by East Renfrewshire home and mobile health monitoring are considerable, starting from zero and reaching almost 500 users in 16 months. There is robust evidence from East Renfrewshire of the contribution of HMHM towards achieving:

- A higher percentage of the population self-managing
- Increased condition control
- Optimised face to face contacts
- Improved access to services

3.16 There was also good evidence submitted of contributions to resources being used more effectively and efficiently and positive patient/service user experience.

4 Significant Clinical Incidents

4.1 Between 01/04/2018 and 31/03/2019 there were 2 incidents which progressed to SCI Investigation.

Directorate	Specialty	Unit	Sub-Category
Mental Health Services	Learning Disabilities	Blythswood House	Sudden Illness/ Deterioration or Collapse
Mental Health Services	Community Mental Health Team	Eastwood Health and Care Centre	Unexpected Death

4.2 Between 01/04/2018 and 31/03/2019 there were 900 patient-related clinical incidents reported.

	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Total
Abscondment / Missing	0	1	0	2	2	1	1	1	0	2	2	0	12
Challenging Behaviour	7	11	7	8	15	17	13	8	12	18	8	15	139
Communication	1	1	0	0	2	3	1	2	1	1	1	1	14
Diet Inappropriate	0	0	0	0	0	0	0	1	0	0	0	0	1
Discharge or Transfer Problem	0	0	0	1	0	0	0	0	0	0	0	1	2
Infection Control	0	0	0	0	0	0	0	0	0	1	0	0	1
Medical Devices/Equipment	1	0	0	0	1	0	0	0	0	0	0	0	2
Medication - Administration	2	4	3	2	5	2	1	2	4	0	3	3	31
Medication - Dispensing/Supply	1	0	1	1	1	1	2	1	2	0	0	2	12
Medication - Monitoring	1	0	0	2	1	0	0	1	0	0	0	0	5
Medication - Patient Induced	0	0	0	0	0	0	0	0	0	0	1	1	2
Medication - Prescribing	0	2	0	0	2	2	1	0	1	0	2	0	10
Patient Observations	0	0	0	0	1	0	0	0	0	0	0	0	1
Pressure Ulcer Care	7	3	3	4	5	0	4	4	0	7	4	4	45
Self-Harm	49	52	43	41	45	47	30	45	46	61	40	32	531
Suicide	1	0	0	0	1	0	0	0	0	0	0	0	2
Treatment Problem	0	0	0	0	1	0	0	0	1	0	1	1	4
Other Incidents	5	11	9	5	11	5	9	6	6	5	5	9	86
Total	75	85	66	66	93	78	62	71	73	95	67	69	900

5 Clinical Effectiveness

5.1 The Clinical Director of East Renfrewshire Health & Social Care Partnership development team and the lead Optometrist for the area have worked on refining and reinforcing the process for signposting patients directly to their local optometrist with any eye problem. Our lead optometrist is providing strong leadership on this and has engaged in a programme of education with his local colleagues. The message appears to be effective, with GPs seeing fewer patients with eye problems and patients receiving an excellent level of care from local optometrists.

5.2 Eastwood Cluster has signed up to a Trello board for sharing clinical effectiveness resources, including national and NHS Greater Glasgow and Clyde protocols for treatments and for sharing clinical audit work and Quality Improvement activities. The other two clusters are in the process of following suit.

5.3 Health Visiting Service; in 2016 the Scottish Government (SG) released the final version of the Revised Universal Pathway. The Pathway presents a core home visiting programme to be offered to all families by Health Visitors as a minimum standard. The programme consists of 11 home visits to all families - 8 within the first year of life and 3 Child Health Reviews between 13 months and 4-5 years. Spanning the antenatal to pre-school period, it ensures the opportunity for Health Visitors to fulfil their role promoting, supporting and safeguarding the wellbeing of children. It was acknowledged that these additional visits will result in an increased pressure on Health Visitors, consequently funding from SG provided for 200 new

Health Visitors across NHS Greater Glasgow and Clyde to reduce caseload sizes to mitigate this.

5.4 A significant recruitment campaign has been ongoing across NHS Greater Glasgow and Clyde to recruit appropriately experienced nurses and support them to undertake the requisite Specialist Community Public Health Nurse qualification. For East Renfrewshire this means we have experienced an incremental increase in the establishment of Health Visitors from 12.3 wte April 2016 to 20.9 wte at end point September 2019 (20.9 wte. includes Team Leads (TL = 1.9 wte) and Clinical Practice Teachers (CPT = 1.8 wte). Due to maternity leave and vacancies the Eastwood team will not be in a state of readiness to commence the pathway until July 2019. The Barrhead team commenced implementation on 1 April 2019.

5.5 UNICEF has awarded East Renfrewshire Health & Social Care Partnership, health visiting service the gold award for their work with the baby friendly initiative (BFI). The service was recognised for continuing improving results for families in East Renfrewshire and was highly commended for the way its services have been developed to ensure there are continued improvements in outcomes for babies, their mothers and families as a whole.

5.6 Uptake of the 27-30 month assessment is better in East Renfrewshire than in NHS Greater Glasgow and Clyde as a whole. However, we would expect this given the relatively high levels of affluence within East Renfrewshire and the correlation between high affluence and uptake.

East Renfrewshire

Uptake Rates	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
% Assess Completed Before 27mth	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
% Assess Completed Between 27mth-33mth	93%	90%	92%	89%	95%	99%	95%	97%	97%	96%	98%	97%
% Assess Completed After 33mth	2%	4%	3%	8%	4%	0%	0%	0%	0%	0%	2%	1%
% Assess Not Completed	5%	6%	5%	4%	1%	1%	5%	3%	3%	4%	0%	2%

NHS Greater Glasgow and Clyde

Uptake Rates	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
% Assess Completed Before 27mth	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%
% Assess Completed Between 27mth-33mth	92%	91%	92%	92%	92%	92%	92%	94%	92%	92%	91%	93%
% Assess Completed After 33mth	2%	2%	3%	2%	3%	3%	2%	2%	3%	3%	3%	1%
% Assess Not Completed	5%	6%	6%	5%	5%	5%	6%	4%	5%	5%	6%	5%

5.7 Our uptake for childhood immunisations is strong compared to boards averages – East Renfrewshire have the highest aggregate uptake across 6 – in – 1 (96%) plus PCV (96%) and Rotavirus (93%) and MenB vaccination (95%) in Greater Glasgow and Clyde.

5.8 Specialist learning disability services have a system-wide clinical governance structure which has representation at meetings from learning disability managers and senior clinicians from all of the six Health & Social Care Partnership areas, specialist learning disability inpatient services, the LD clinical director and general manager, with input from clinical effectiveness, clinical risk, academia, service users and carers.

5.9 The overall aim of the clinical governance model in Specialist Learning Disability Services is to improve quality, ensure safe, effective and person centred equitable services. There are two clinical governance work plans (inpatient and Health & Social Care Partnership Board-wide) which focus on the following areas: Patient

safety, clinical effectiveness, clinical audit, learning and education, research and development, involvement of patient and carers and development of practice/clinical networks.

5.10 Both the inpatient clinical governance and Health & Social Care Partnership - wide clinical governance meetings are held on a bi-monthly basis. The inpatient clinical governance activity is reported via the Health & Social Care Partnership Primary Care & Community Clinical Governance Forum meeting.

5.11 Each Health & Social Care Partnership area completes an exception report in advance of the bi-monthly meetings. Exception reports are a standing agenda item at the meeting. All LD SCI reports and all Community LD DATIX incidents are reviewed at the meetings. Progress with any board wide pathway or network development is also reviewed.

5.12 The inpatient service has been successful in gaining AIMS accreditation. To date NHS Greater Glasgow and Clyde are only the second learning disability service in Scotland to have achieved this accreditation. In order to get to the standard required, there were six years of continuous planned work with over 50 improvement projects undertaken and completed. A new plan of further quality improvement work is being to develop and will help to ensure the inpatient service retains its accreditation status over the next 3 years.

5.13 The main issue for the Learning Disability service is the level of delayed discharges for patients. This continues to have an impact on our ability to admit people who require inpatient care and on system wide MH beds where patients can be waiting for transfer. The service have had recent success with two patients move on to new community placements after meticulous planning and joint working so this is a positive step forward. A suite of system wide improvements has been developed and will be monitored through clinical and care governance arrangements for the service.

5.14 The Learning Disability board lead Professional Nurse Advisor has been selected to participate in the Queen's Nurse Programme which brings together community nurses who want to develop their professional skills and who share common values, with a shared title. The title of 'Queen's Nurse' (QN) is available to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice. As part of the participation in this programme the PNA will focus on a quality improvement initiative.

5.15 Ongoing from the previous year, patients prescribed DPP4 inhibitors for diabetes were reviewed in all practices by the prescribing team. Reviews ascertained whether patients' diabetes control had improved on these medicines and if not improved by a minimum level, had their medicine discontinued. Those who had benefitted from treatment were then assessed for suitability for switching to the formulary preferred drug, alogliptin. This ensured these were prescribed in line with the NHS Greater Glasgow and Clyde guidelines.

5.16 Patients prescribed lidocaine patches were reviewed for ongoing effectiveness and were given advice on trialling periods without to ensure ongoing benefit. A number of patients had treatment stopped or changed as a result of these reviews. This ensures NHS resources are being utilised to their full potential and not spent on treatments that are not having the desired outcome for individual patients.

5.17 East Renfrewshire Health & Social Care Partnership workforce plan, aims to ensure the workforce has the skills and competencies required to take on new roles which deliver future models of care that are consistent with the Scottish Government's aims to deliver public sector collaboration and ambitions. Utilisation of the Community Nursing Workforce Assessment Tools provides an important consistent evidence based tool for establishing the staffing needs of a range of services. The national tools were developed in partnership with key stakeholders, researched, tested and refined with final ratification and validation. To date the Nursing and Midwifery Workforce Workload Planning Programme (NMWWPP) has facilitated local implementation and several runs of the tools have been completed within Children and Families Service, District Nursing Learning Disability and Mental Health.

5.18 The Health and Care (Staffing) (Scotland) Bill was introduced by the Cabinet Secretary for Health and Sport on 23 May 2018. The timeline for the development and approval of the Bill has now reached the final stage: Stage 3. The Health and Care (Staffing) Scotland Bill will place a legal requirement on NHS boards and care services to ensure that appropriate numbers of suitably trained staff are in place at all times which will include the use of the Nursing and Midwifery Workforce Workload Planning Programme tools. The Nursing and Midwifery Workforce Workload Planning Programme tools form an important building block to ensure safe staffing levels alongside listening to highly skilled professionals enabling them to exercise professional judgment and having flexibility in the system to adapt to real time changes in patient dependency and acuity.

5.19 The output from the run of the tools is the focus of discussion within respective teams and services. It is recognised that further work is required to further improve data quality. Output of the runs has been shared with local teams encouraging ownership and the opportunity for the teams to scrutinize, discuss and develop local action plans.

6 Clinical Governance Arrangements

6.1 The role of the Clinical and Care Governance Group is to consider matters relating to governance, risk management, service user feedback and complaints, standards, education, professional registration and validation, learning, continuous improvement and inspection activity.

6.2 Specifically the group is responsible for the following:

- Providing assurance to the Integration Joint Board (IJB), the Council and NHS, via the Chief Officer, that the Professional standards of staff working in Integrated Services are maintained and that appropriate professional leadership is in place
- Reviewing significant and adverse events and ensure learning is applied
- Supporting staff in continuously improving the quality and safety of care
- Ensuring that service user/patient views on their health and care experiences are actively sought and listened to by services
- Creating a culture of quality improvement and ensuring that this is embedded in the organisation

6.3 The group is chaired by the chair of the Integration Joint Board, along with Integration Joint Board members, membership includes Chief Officer East Renfrewshire Health & Social Care Partnership, Clinical Director, Chief Social Work Officer, Professional Nurse Advisor, AHP Professional Lead (OT), GP

representative, Optometry Lead, Pharmacy Lead, NHS Greater Glasgow and Clyde Clinical Effectiveness representative, Third and Independent Sector representatives, and patient and carer representatives.

6.4 The group meets four times a year and the agenda is structured to cover the areas of:

- Professional Leadership/Standards including registration and practice assurance
- Improvement Activity including self-evaluation and clinical governance actions
- Service Care Group Activity
- Patient/Service User Views including complaints, surveys and feedback
- Quality and Safety of Care including public protection , Inspections and Contract Monitoring
- Review of Significant and Adverse Events

6.5 The Clinical Director completes an exception report 6 times per year to submit to the Partnership and Community Clinical and Care Governance Forum (PCCCGF). The Clinical Director and Chief Nurse attend the meeting. An arrangement is in place for the Chief Nurse to provide an update report to the group in the absence of the Clinical Director.

6.6 The Clinical and Care Governance Committee met on 20th June 2018, 31st October 2018 and 6th March 2019. At the meeting of the Integration Joint Board on 20 March 2019, it was agreed to introduce new arrangements for the oversight of clinical and care governance within the Health and Social Care Partnership. The first meeting of the Clinical and Care Governance Group takes place on 5th June 2019.