Clinical and Care Governance Committee

Thursday, 27 October 2022

Council Chambers

NOTICE IS HEREBY GIVEN that a Meeting of the **Clinical and Care Governance Committee, Council Chambers**, **Council Office, High Street, Elgin, IV30 1BX** on **Thursday, 27 October 2022** at **14:00** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

SEDERUNT

Mr Derick Murray (Chair)

Professor Siladitya Bhattacharya (Voting Member)
Councillor Peter Bloomfield (Voting Member)
Councillor Scott Lawrence (Voting Member)
Mr Graham Hilditch (Member)

Mr Ivan Augustus (Non-Voting Member)
Ms Karen Donaldson (Non-Voting Member)
Ms Jane Ewen (Non-Voting Member)
Mrs Val Thatcher (Non-Voting Member)

Clerk Name:	Tracey Sutherland
Clerk Telephone:	07971 879268
Clerk Email:	committee.services@moray.gov.uk

MINUTE OF MEETING OF THE CLINICAL AND CARE GOVERNANCE COMMITTEE

Thursday, 25 August 2022

Council Chambers, Council Office, High Street, Elgin, IV30 1BX

PRESENT

Professor Siladitya Bhattacharya, Mr Simon Bokor-Ingram, Mr Sean Coady, Mr Graham Hilditch, Councillor Scott Lawrence, Mr Derick Murray, Ms Samantha Thomas, Councillor Kathleen Robertson (for Councillor Peter Bloomfield)

APOLOGIES

Mr Ivan Augustus, Councillor Peter Bloomfield, Ms Karen Donaldson, Ms Sonya Duncan, Ms Jane Ewen, Ms Jane Mackie, Ms Deborah O'Shea, Mr Neil Strachan, Mrs Val Thatcher

IN ATTENDANCE

Also in attendance at the above meeting were Sammy Robertson, Consultant Practitioner, Chris Wiles, Consultant Clinical Psychologist, Laura Sutherland, Acting Locality Manager/Home First Programme Lead, Alison Smart, Service Manager and Tracey Sutherland, Committee Services Officer.

1. Chair

The meeting was chaired by Mr Derick Murray.

2. Welcome and Apologies

The Chair welcomed everyone to the meeting and apologies were noted.

3. Declaration of Member's Interests

There were no declarations of Members' Interests in respect of any item on the agenda.

4. Minute of Meeting of 26 May 2022

The minute of the meeting of 26 May 2022 was submitted and approved.

5. Action Log - 26 May 2022

The Action Log for the meeting of 26 May 2022 was discussed and updated.

6. Complaints Report Quarter 1

A report by the Chief Nurse informed the Committee of complaints reported and closed during Quarter 1 (1 April 2022 - 30 June 2022).

Following consideration the Committee agreed to:

i) note the totals, lessons learned, response times and action taken for complaints completed within the last quarter; and

ii) note that a draft Health and Social Care Moray (HSCM) Annual Complaints Report for 2021/22 will be presented tot he October meeting.

7. Clinical and Care Governance Group Escalation Q1 Report

A report by the Chief Nurse informed the Committee of progress and exceptions reported to the Clinical and Care Governance Group during quarter 1 of 2022/23 (1 April to 30 June 2022).

Following consideration the Committee agreed to note the contents of the report.

8. Out Of Hours Mental Health Service Provision for 16 to 18 year olds

A report by the Service Manager, Child and Adolescent Mental Health Services (CAMHS) updated the Committee on progress towards addressing the previous gaps in out-of-hours mental health service provision for young people aged 16-18 years in Moray, the current risk mitigation plan and longer terms plans.

Following consideration the Committee agreed:

i) to note the contents of this update report; and

ii) agreed that a further update report should be presented to the next meeting.

9. Three Conversations Approach

A report by the Head of Service/Chief Social Work Officer informed the Committee of progress made regarding the initial implementation of the Three Conversation Model within Health and Social Care Moray (HSCM).

Following consideration the Committee agreed to note:

i) the impact of the implementation of the Three Conversations Approach thus far; and

ii) the future plans and next steps for this approach in Moray.

10. Unmet Need Report

A report by the Head of Service/Chief Social Work Officer updated the Committee on the current position on unmet need within Health and Social Care Moray (HSCM).

Following consideration the Committee agreed to:

i) note the current situation within HSCM and the mitigation actions that have been introduced;

ii) note the continuing additional pressures placed upon HSCM staff; and

iii) recognise the fragility of any improvements and the long term impact on staff.

11. Strategic Risk Register Report

A report by the Chief Officer provided the Committee with an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated August 2022.

Following consideration the Committee agreed to note:

i) note the updated Strategic Risk Register included as Appendix 1; and

ii) the Strategic Risk Register will be further refined to align with the transformation and redesign plans as they evolve.

12. Items for Escalation to MIJB

The Chair proposed escalating the Unmet Need Report to the Moray Integration Joint Board as it is an ongoing issue.

In response the Chief Officer, suggested that whilst this persists that there is coverage in his Chief Officer Report to provide a regular update on the Unmet Needs situation.

The Committee agreed that this would be a good resolution.

MEETING OF MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE

THURSDAY 25 AUGUST 2022

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY	UPDATE OCTOBER 2022
1.	Progress Update for Clinical and Care Governance Developments	A follow up workshop to be arranged in April/May 2022 on developments in relation to governance arrangements and assurance framework.	30 June 2022	Chief Social Worker and Lead Nurse	On Agenda
2.	Out of Hours Primary Care GMED Report	Report to be circulated to Aberdeen City and Shire Integration Joint Boards for further scrutiny		Chief Officer	Completed
3.	Items for Escalation to MIJB	The Committee agreed to escalate the Unmet Need in Health and Social Care Moray to the MIJB	June 2022	Chief Officer/Head of Service	New section added to the Chief Officers Report which will regularly update the IJB on the situation.
4.	CCG Escalation Report – Quarter 1	Report and Action plan to be presented following the Adult Support and Protection Inspection		Chief Officer	On Agenda
5.	CCG Escalation Report – Quarter 1	Copy of the briefing from the Director of Pharmacy regarding staffing issues to be circulated to CCG Committee		Chief Officer	Update included in Escalation report

6.	CCG Escalation Report – Quarter 1	Report on the results of the patient surveys from GMED to be presented to next meeting of CCG	October 2022	Chief Nurse	Update included in Escalation report

REPORT TO: **CLINICAL AND CARE GOVERNANCE COMMITTEE ON 27 OCTOBER 2022**

SUBJECT: **HEALTH AND SOCIAL CARE MORAY (HSCM) CLINICAL AND CARE GOVERNANCE GROUP ESCALATION REPORT FOR QUARTER 2 (JULY TO SEPTEMBER 2022)**

BY: **CHIEF NURSE, MORAY**

1. REASON FOR REPORT

1.1. To inform the Clinical and Care Governance Committee of progress and exceptions reported to the Clinical and Care Governance Group during quarter 2 of 2022/23 (1 July up to 30 September 2022).

2. RECOMMENDATION

2.1 It is recommended that the Committee consider and note the contents of the report.

3. BACKGROUND

3.1. HSCM Clinical Governance Group was established as described in a report to this Committee on 28 February 2019 (para 7 of the minute refers).

3.2. The assurance framework for clinical governance was further developed with the establishment of the Clinical Risk Management Group (CRM) as described in a report to this Committee on 30 May 2019 (para 7 of the minute refers).

3.3. As reported to this Committee on 29 October 2020 (para 5 of the minute refers) Social Care representatives attend the Clinical Governance Group so the group was renamed HSCM Clinical and Care Governance Group. The group is co-chaired by Samantha Thomas, Chief Nurse - Moray and Tracy Stephen, Head of Service/Chief Social Work Officer.

3.4. The agenda for the Clinical and Care Governance Group follows a 2 monthly pattern with alternating agendas to allow for appropriate scrutiny of agenda items and reports. A reporting schedule for Quality Assurance Reports from Clinical Service Groups / departments is established. This report contains information from these reports and further information relating to complaints and incidents / adverse events reported via Datix; and areas of concern / risk and good practice shared during the reporting period. Exception reporting is utilised as appropriate. Since April 2020, the 3 minute brief template has been

used for services to share their updates; this approach has resulted in positive feedback from service managers and group members.

3.5. The Clinical and Care Governance Group have met twice during this reporting period.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Audit, Guidelines, Reviews and Reports

4.1 Relevant Audits, Guidelines Reviews and Reports are tabled and discussed. These include local and national information that is relevant to HSCM, for example, recommendations from Health Improvement Scotland (HIS) reports from other areas which require to be discussed and assurance given that services in Moray are aware of these and have process in place to meet/ mitigate these recommendations. Overview from Quarter 2 2022/23 is listed below:

- CRM Minutes
- HIS – Unannounced Inspection Report: University Hospital Crosshouse NHS Ayrshire & Arran
- Service Updates:
    - GMED
    - Pharmacy
    - Forres & Lossiemouth Locality
    - Moray Integrated Drug & Alcohol Services
    - Moray Integrated Mental Health Services
    - Moray Learning Disability Services
    - Moray GP/Primary Care Contracts Team
- Adverse Events and DoC
- HSCM Risk Register
- Complaints / Feedback
- Update from Practice Governance Group

Areas of achievement / Good Practice

4.2 At the last Committee meeting GMED reported working on improving the quality of the service that is provided to patients across NHS Grampian and a number of initiatives were described. Updates have been added in, in bold, below:

- Working with various stakeholders, including Scottish Ambulance Service (SAS), NHS24, Emergency Department (ED) and Mental Health to identify how patient pathways can be streamlined to ensure quality of patient care is improved. **GMED continues to work with stakeholders on patient pathways and professional to professional calls.**
- Regular Continuing Medical Education (CME) sessions are organised for the clinical team to ensure national clinical standards and guidelines are shared and reliably implemented within GMED for a specified condition. **These are ongoing and aim to continuously ensure that patients receive evidence-based and consistent care.**
- Patient surveys to measure patient satisfaction with the quality of care provided by GMED service and clinical note audits – **these were paused due to an IT system failure and a staff vacancy. This post has now been recruited too, and it is anticipated that this work will resume once GMED can totally return to 'business and usual'.**

4.3 GMED – changes made to the front end of main IT system to align each health board in Scotland with national standards.

4.4 Forres and Lossiemouth Locality:

- District Nurse and Social Work pathway are in place for admissions to Varis Unscheduled Short Stay Flats – the criteria for admission has been updated and shared with all key stakeholders. Forres Neighbourhood Care Team staff discuss all potential admissions.
- Forres Treatment and Care Hub provide minor illness and day centre treatments for patients that would otherwise have to travel through to Dr Gray's Hospital.

4.5 Moray Integrated Drug and Alcohol (D&A) Services:

- Additional funding from the Alcohol Drug Partnership has allowed recruitment to additional nursing, admin, psychology and medical posts to support service as well as supporting two further nurses to undertake non-medical prescribing.
- Moray Integrated D&A Service will be a pilot site for the role out of TRAK HEAT waiting list module, likely to commence around September. This will provide more accurate reporting of waiting times.
- Systems in place to review Drug Related Deaths and Multi-Agency reviews taking place to discuss high risk patients in a timely manner, engaging with other stakeholders involved in the patient's care. A report on Drug Related Deaths in Moray is included in today's agenda.

4.6 Moray Integrated Mental Health Services:

- Psychological therapy services – significant reduction in waiting lists was reported in August - waiting lists reduced from 83 people and longest wait 36 weeks, to 40 people longest wait of 25 weeks. Unfortunately due to an increase in referrals to the service, alongside capacity issues within the team the longest wait at the time of reporting is now 27 weeks with 53 people waiting.
- Staffing – successful recruitment to consultant psychiatrist and psychotherapist posts. Start dates confirmed for September and October respectively. Funding secured from Scottish Government to recruit to a band 6 Post Diagnostic Support nurse.

4.7 Pharmacy – recruitment going well – there will be a full quota of pharmacists and technicians as set out in the original plan. Improved clinical outcomes include providing patients with more timely access to medication, staff accreditation, increase in polypharmacy complex medication reviews across all practices and an increase in senior pharmacists input to clinics.

4.8 Primary Care Contracts Team – GP practices are experiencing an increase in challenging behaviour from members of the public – work has commenced with NHS Grampian Feedback and Engagement team to work with patient groups across all independent contractor groups to address perceptions and issues.

4.9 Learning Disability Team have successfully appointed an administrator and an Advanced Practitioner to the social work team. The team have also recruited to the bank a Speech and Language Therapist to assist in reducing waiting list.

4.10 Clinical and Care Governance Developments – an update will be provided to Committee today with regards to progress in relation to governance arrangements and assurance framework.

4.11 Through routine monitoring of adverse events within community hospitals it has been noted there has recently been a spike in the number of falls within Moray Community Hospitals. The newly appointed Interim Clinical Governance (CG) Coordinator will be working directly with teams in Community Hospitals to create and implement effective strategies to care for those patients who are vulnerable to having falls.

4.12 Adults with Incapacity Training – a number of training sessions have been held with further dates circulated. This training focuses on discharge from hospital to a care home for people who lack capacity and is aimed at NHS colleagues across the partnership. HSCM committed to deliver this training following the Mental Welfare Commission Report: Authority to Discharge.

4.13 The Adult Support and Protection team undertook a visit to a care home following some referrals regarding delivery of care and support. The referrals did not progress to further adult support and protection intervention, however it did highlight possible learning points regarding communication and use of terminology. It is proposed that a standard recording template or system is used to provide a consistent way of recording to reduce the risk of misinterpretation of information and terminology between health professionals. A working group will be established to take this forward.

Clinical Risk Management (CRM)

4.14 The Clinical Risk Management (CRM) group meet every 2 weeks to discuss issues highlighted on the HSCM Datix dashboard. This includes Level 1 and Level 2 investigations, Complaints, Duty of Candour and Risks.

4.15 The group is attended by members of the senior management team, clinical leads, chief nurse and relevant service managers / consultants. The purpose is to ensure that senior managers are assured of the standards of services and that where necessary investigations are carried out appropriately and learning opportunities identified.

4.16 An action log is produced following each meeting and is administered and monitored. Individual services can be invited to attend to offer further scrutiny and assurance. It has been agreed that the action log and updates will be presented and discussed at HSCM Systems Leadership Group (SLG) on a monthly basis. This will allow clear escalation process for any ‘High’ or ‘Very High’ risks that are identified. This will also ensure SLG have oversight of all ‘High’ and ‘Very High’ risks held by HSCM.

4.17 The Interim CG Coordinator will coordinate CG intelligence to inform the partnership of local risks relevant to patient safety, providing information to Clinical Leads, Service Managers and local governance groups and committees. A schedule of meetings for CRM group are now resumed on a fortnightly basis.

Complaints and Feedback

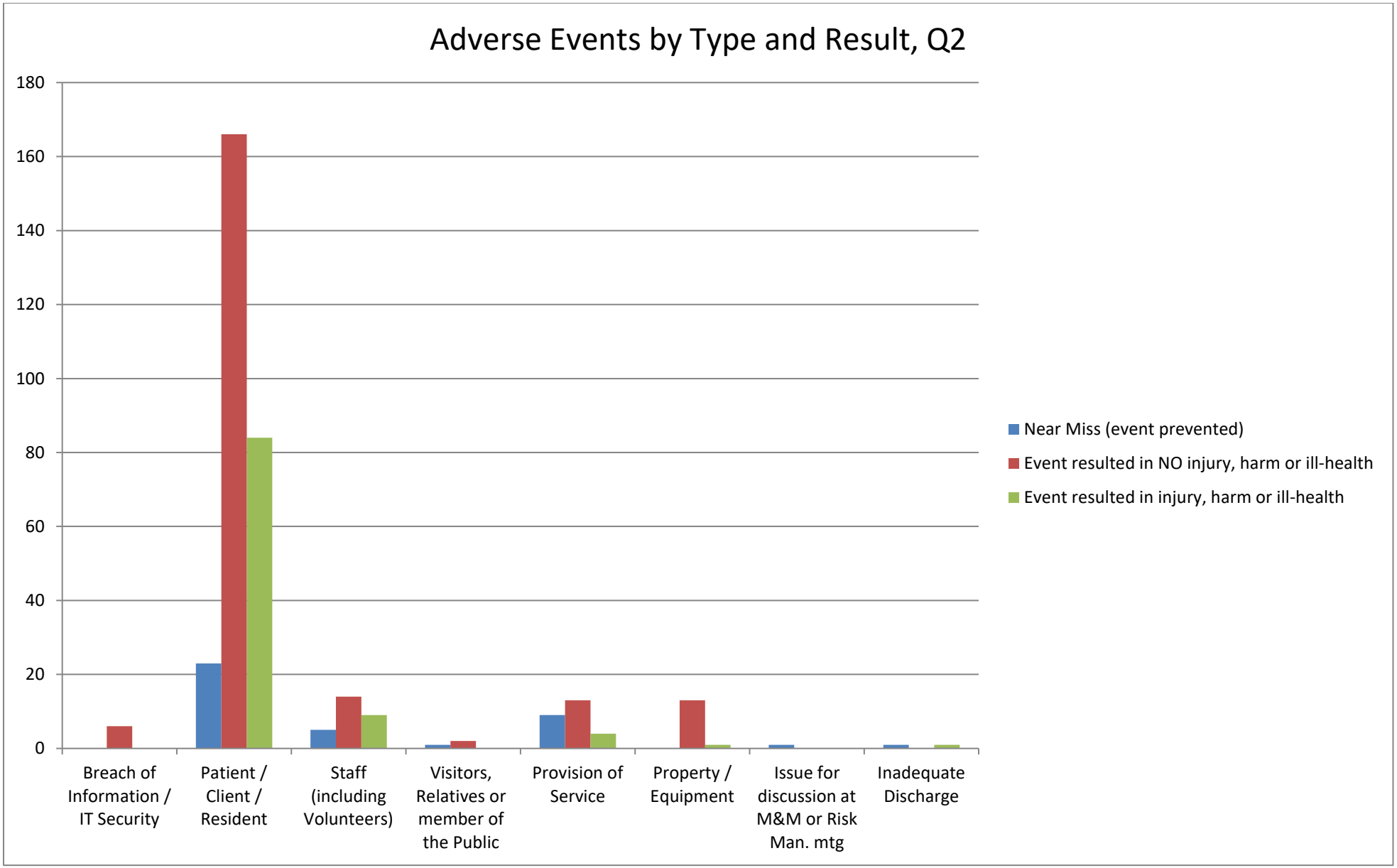
4.18 HSCM complaints information for Quarter 2, 2022/23 is included in a separate report on today's agenda.

Adverse Events

4.19 Adverse Events by Category and Level of Review Reported on Datix (Quarter 2, 2022/23)

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	Total
Abusive, violent, disruptive or self-harming behaviour	61	2	63
Access, Appointment, Admission, Transfer, Discharge (Including Absconders)	15	0	15
Accident (Including Falls, Exposure to Blood/Body Fluids, Asbestos, Heat, Radiation, Needlesticks or other hazards)	117	0	117
Clinical Assessment (Investigations, Images and Lab Tests)	1	0	1
Consent, Confidentiality or Communication	5	0	5
Diagnosis, failed or delayed	1	0	1
Financial loss	2	0	2
Fire	5	0	5
Implementation of care or ongoing monitoring/review (inc. pressure ulcers)	10	1	11
Infrastructure or resources (Staffing, Facilities, Environment, Lifts)	17	0	17
Medical device/equipment	2	0	2
Medication	14	1	15
Other - please specify in description	15	0	15
Patient Information (Records, Documents, Test Results, Scans)	8	1	9
Security (no longer contains fire)	5	0	5
Treatment, Procedure (Incl. Operations or Blood Transfusions etc.)	3	0	3
Total	**281**	**5**	**286**

* At time of reporting 66 AE had not yet been allocated a Level of Review


Adverse Events by Type and Result, Q2
180
160
140
120
100
80
60
40
20
0
Breach of Information / IT Security
Patient / Client / Resident
Staff (including Volunteers)
Visitors, Relatives or member of the Public
Provision of Service
Property / Equipment
Issue for discussion at M&M or Risk Man. mtg
Inadequate Discharge
Near Miss (event prevented)
Event resulted in NO injury, harm or ill-health
Event resulted in injury, harm or ill-health

4.20 Adverse Events by Service and Level of Review Reported on Datix (Quarter 2, 2022/23)

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	**Total**
Allied Health Professionals	9	0	9
Community Hospital Nursing	71	1	72
Community Nursing	20	2	22
Community Pharmacy	0	1	1
General Practice	6	0	6
GMED	5	0	5
Grampian Diabetes & Heart Failure Nurses MCN	1	0	1
Mental Health - Adult Mental Health	82	1	83
Mental Health - Old Age Psychiatry	68	0	68
Mental Health - Specialisms	2	0	2
Out of Hours (Excluding GMED)	2	0	2
Primary Care	1	0	1
Public Dental Service	13	0	13
Administration	1	0	1
Total	**281**	**5**	**286**

* At time of reporting 66 AE had not yet been allocated a Level of Review

4.21 Adverse Events by Type and Severity Reported on Datix (Quarter 2, 2022/23)

	NEGLIGIBLE: Negligible/no injury or illness, negligible/no disruption to service, negligible/no financial loss	MINOR: Minor injury or illness, short term disruption to service, minor financial loss	MODERATE: Significant injury, externally reportable e.g. RIDDOR, some disruption to service, significant financial loss	MAJOR: Major injury, sustained loss of services, major financial loss	**Total**
Breach of Information / IT Security	6	0	0	0	6
Patient / Client / Resident	198	65	7	2	272
Staff (including Volunteers)	20	8	0	0	28
Visitors, Relatives or member of the Public	3	0	0	0	3
Provision of Service	22	3	1	0	26
Property / Equipment	13	1	0	0	14
Issue for discussion at M&M or Risk Man. mtg	1	0	0	0	1
Inadequate Discharge	1	1	0	0	2
Total	**264**	**78**	**8**	**2**	**352**

4.22 All adverse events by result by Quarter

	2020/21 Quarter 1	2021/22 Quarter 2	2021/22 Quarter 3	2021/22 Quarter 4	2022.23 Quarter 1	**2022.23 Quarter 2**
Occurrence with NO injury, harm or ill-health	193	239	271	189	218	214
Occurrence resulting in injury, harm or ill-health	80	61	87	79	89	98
Near Miss (occurrence prevented)	34	37	25	31	29	40
Property damage or loss	0	0	0	0	0	0
Death	0	0	1	0	0	0
Total	**307**	**337**	**383**	**299**	**336**	**352**

4.23 Adverse Events by Severity Reported on Datix by Quarter

	2020/21 Quarter 1	2021/22 Quarter 2	2021/22 Quarter 3	2021/22 Quarter 4	2022.23 Quarter 1	**2022.23 Quarter 2**
Negligible	234	281	308	231	259	264
Minor	66	48	72	64	70	78
Moderate	6	8	2	2	4	8
Major	1	0	0	2	1	2
Extreme	0	0	1	0	2	0
Total	**307**	**337**	**383**	**299**	**336**	**352**

All adverse events have the appropriate level of investigation implemented.

At the time of reporting some events had yet to be allocated a Level of Review on Datix.

4.24 Findings and Lessons Learned from incidents and reviews:

- Staff reminded of the importance of accurate record keeping with monthly audits of patient notes to ensure record keeping is maintained to a high standard with clear and concise documentation.
- Earlier intervention to increase community nursing visits to patient when wound was assessed as deteriorating and timely updating of nursing documentation.
- Review of staff communication processes of patient information to administrative staff – staff to double check information on professional author of letter and medical IT systems.
- Teams reminded to check all active interventions for patients when scheduling new ones so that there is no duplication of work.
- Recirculation of the Standard Operating Procedure for labelling of blood tubes in patient homes.

4.25 A Level 1 review consists of a full review team who have been commissioned to carry out a significant event analysis and review, reporting findings and learning via the division/ service governance structures.

4.26 There are currently 6 Level 1 reviews in progress (at the time of reporting).

HSCM Risk Register

4.27 New risks identified on Datix are discussed at CRM. There have been 2 new risks reported during Quarter 2, both identified as 'High'.

4.28 There are 3 "Very High" risks currently on the register. These are being closely monitored by the CRM and senior management team.

4.29 Each Clinical Service Group/Department highlights risks associated with their service, which are then discussed at CRM. The risk register is routinely reviewed with leads with guidance and support provided regarding updates. An exercise is underway to review and improve this process. This will involve an in-depth analysis of the existing structure, working closely with teams, to develop a more streamlined process for the management of risk across the partnership.

Duty of Candour

4.30 2 events were considered for Duty of Candour (DoC) during Quarter 2, these are both still under investigation.

Items for escalation to the Clinical and Care Governance Committee

4.31 Update on Pharmacy Closures – Moray has 26 Registered Community Pharmacies. They are obliged to meet professional standards which include opening premises and provision of services agreed, but this is not an actual contract. The community pharmacy can therefore request authorisation to close for a short period in absolute emergency situations. Closures in Moray have been lower than that in other areas, peaking to 42 episodes in the month of July 2022, but an increasing trend was noted over the last year. Multiple pharmacies have been more affected with Lloyds, then Boots, being most affected in Moray. Various discussions have been had with Lloyds' area manager but there is a recognised workforce shortage. NHS Grampian will

attempt to discuss improvements using possible loss of extra funded contractual services as a lever.

4.32 Adult Support and Protection – the Multi-Agency Improvement Action Plan is on today's agenda. On 28 July 2022 the Scottish Government launched the revised Code of Practice for the Adult Support and Protection (Scotland) Act 2007. Information specific to NHS and Locality Authority has been extrapolated from these documents, put into briefing notes and circulated appropriately to staff. The new key points within the document are primarily about clarity and emphasis on certain areas of Adult Support and Protection activity.

4.33 Adults with Incapacity – Capacity Assessments: issue in identifying an appropriate person to complete capacity assessments which are required for applications for guardianship. There is no formal pathway for this within the NHS – this is a national problem and not specific to Moray. The Clinical and Care Governance Group note the inherent risk associated with delaying the progress of guardianship applications and supports the development of a pathway to obtaining capacity assessments. This is has been escalated through the appropriate channels within NHS Grampian.

4.34 GMEDs main IT operating system suffered major outage at the beginning of August 2022. GMED continue to operate under business continuity conditions to date. During this period GMED have reviewed and adapted their continuity plans to deliver safe patient care whilst also implementing a temporary system. The team continue to address and work through the challenges of the recovery plan and the additional work that generates.

4.35 Recruitment challenges continue for NHS dentistry across Scotland. There are currently no local independent NHS dental practices in Moray accepting new patients for NHS registration. Urgent dental care provision in Moray remains comprehensive for all, and care for registered patients remains relatively stable. Scottish Government interim funding package for local NHS dentists was revised in April 2022 and a further revision is expected this month. Two posts in the European Graduate Scheme have been secured for Moray, this should result in new registration places being made available to the population. Scottish Dental Access Initiative Grants and Recruitment & Retention Allowances have been approved for Moray, to encourage new dentists and/or practices into the area – however there are currently no applications.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"
As set out within Annex C of the Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 Clinical and Care Governance Framework.

(b) Policy and Legal
Clinical and Care Governance requirements are set out within the Moray Health and Social Care Integration Scheme. Appropriate arrangements

must be in place to ensure and evidence good governance in meeting duties under the Public Bodies (Joint Working) (Scotland) Act 2014.

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

There are systems and processes in place across service areas to support clinical governance, providing assurance to the HSCM Senior Leadership Team and to the Clinical and Care Governance Committee. There are platforms within Health and Social Care to discuss and share good practice, learning and challenges.

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

Adverse events and complaints provide significant information on trends relating to risk and an encouraging opportunity for learning across the system. Regular monitoring of this is critical to ensure continuous improvement and the ambition of achieving excellence in our delivery of high quality care and treatment.

The local Clinical Risk Management (CRM) group reviews all events logged on Datix, ensuring risk is identified and managed.

(e) Staffing Implications

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

(f) Property

None directly arising from this report.

(g) Equalities/Socio Economic Impact

There is no requirement for an equality impact assessment because there is no change to policy required as a result of this report.

(h) Climate Change and Biodiversity Impacts

None directly arising from this report.

(i) Directions

None directly arising from this report.

(j) Consultations

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

- HSCM Clinical and Care Governance Group members

- Sonya Duncan, Corporate Manager
- Tracey Sutherland, Committee Services Officer, Moray Council

6. CONCLUSION

6.1 The HSCM Clinical and Care Governance Group are assured that issues and risks identified from complaints, clinical risk management, internal and external reporting, are identified and escalated appropriately. The group continues to develop lines of communication to support the dissemination of information for action and sharing of good practice throughout the whole clinical system in Moray. This report aims to provide assurance to the Moray Integration Joint Board Clinical and Care Governance Committee that there are effective systems in place to reassure, challenge and share learning.

Author of Report: Isla Whyte, Interim Support Manager, HSCM Background Papers: with author

Ref:

REPORT TO: **CLINICAL AND CARE GOVERNANCE COMMITTEE ON 27 OCTOBER 2022**

SUBJECT: **ADULT SUPPORT AND PROTECTION MULTI-AGENCY IMPROVEMENT PLAN**

BY: **CONSULTANT PRACTITIONER, MORAY ADULT SUPPORT AND PROTECTION**

1. REASON FOR REPORT

1.1. To inform the Committee of the Adult Support and Protection (ASP) Multi-agency Improvement Plan in place following the recent Joint Inspection of ASP in the Moray partnership.

2. RECOMMENDATION

2.1. It is recommended that the Clinical and Care Governance Committee considers and notes:

i) the Multi-agency Improvement Plan and progress to date; and

ii) the systems in place to monitor and progress actions within the plan

3. BACKGROUND

3.1 The joint inspection of the Moray partnership took place between March and May 2022. The Care Inspectorate asked the Moray partnership to develop an improvement plan to address the priority areas for improvement identified. The Care Inspectorate will monitor progress implementing the plan.

3.2. The Multi-agency Improvement Plan builds upon Moray's original improvement action plan formulated in 2019 following a series of engagement and consultation events and multi-agency workshops with the purpose of giving a clear foundation and oversight to ASP activities in Moray.

3.3. The structure of the plan has changed over time and has been further influenced by the most recent Joint Inspection in 2022 highlighting areas for development. This plan is a multi-agency plan and is the tool used within Adult Protection Committee(APC) to provide assurance to all partners of progression and development in the work carried out.

3.4. On observation members will see that agency activity is colour coded, and that areas of priority following the inspection have been highlighted pink. Following discussion with the Care Inspectorate further work is underway to better reflect specific actions in the plan back to the recommendations of the Joint Inspection. This will not impact on the working of the plan – but rather, should direct the reader directly to the priority areas. These areas are the primary focus, however other areas of the plan may be actioned and progressed to reflect increased capacity. The updated plan indicates the priority workstreams of Moray's APC – ICT and recording; Lived Experience and Quality Assurance

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The initial self-evaluation activities identified 6 main workstreams, and this formed the foundation of the plan. Since the Joint Inspection a 7th workstream has been identified. Initially, Quality Assurance was intertwined within the plan - this was an area of improvement for the partnership - and as such required its own section. The Moray partnership recognise the benefit of working together with all partners and understands the task ahead in Moray for ASP and working together will only strengthen the partnership and delivery.

4.2. Health and Social Care Moray (HSCM) will engage and provide all partners with the assurance needed to monitor adult support and protection activity and it is important to continue to be honest and transparent about the improvement activities and the deadlines set.

4.3. The Improvement and Planning sub group of the Moray APC meets on a 4 weekly basis. This group is multi-agency and has been formed to discuss protection and allocation of tasks and will have full oversight of the improvement plan. An improvement and planning feedback group will meet 3 weeks prior to each APC. This is to ensure all stakeholders are involved and consulted on progress and actions. This larger group will be involved in agreeing progress thus far and ensuring the improvement plan is sufficiently updated. The plan will then be presented to APC at each meet. The project sponsor is the Chief Social Work Officer.

4.4. The Local Authority have also invested in using Pentana audit management software. The plan has been inputted onto the software system and assists in measuring outcomes and tasks completed - resulting in giving a better oversight to work undertaken and clear workstreams. This is new to Moray and an area that is hoped will provide better strategic oversight in ASP and assist in better efficiency and communication to all partners.

4.5. NHS Grampian (NHSG) will also be progressing further ASP improvements via a NHSG specific ASP Improvement Plan. This plan is coordinated and led by the NHSG Public Protection team, and include some of the actions from the Moray multi-agency plan, but also encompasses wider 'Grampian wide' initiatives – where a once for Grampian approach is thought to be beneficial on grounds of resource use and consistency.

4.6. This NHSG ASP Improvement Plan is regularly reviewed by the NHSG Adult Protection Group and overseen by the NHSG Public Protection Committee. There are direct lines of communication and updates between the NHSG Adult Public Protection lead and the Moray ASP Consultant Practitioner – ensuring

that both the local Moray Multi-Agency Improvement Plan and the NHSG wide plan remain synchronised.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"
This report supports the Moray Strategic Plan in relation to Partners in Care, making choices and taking control over decisions affecting our care and supporting the outcome that people are safe.

(b) Policy and Legal
The Adult Support and Protection (Scotland) Act 2007 is the main legal reference points for this project which the MIJB are legally responsible for.

(c) Financial implications
No financial implications as a direct result of this report.

(d) Risk Implications and Mitigation
The improvement plan will implement robust systems and processes in response to the Care Inspectorate's findings, with a multi-agency approach. Regular monitoring and reviewing of new processes are critical to ensure continuous improvement.

(e) Staffing Implications
None as a direct result of this report.

(f) Property
None as a direct result of this report.

(g) Equalities/Socio Economic Impact
Not required as there are no changes to policy.

(h) Climate Change and Biodiversity Impacts
None as a direct result of this report.

(i) Directions
None as a direct result of this report.

(j) Consultations
ASP Planning and Improvement Sub Group.

6. CONCLUSION

6.1. The report aims to provide assurance to this Committee that there is effective processes in place to monitor and progress actions in the plan.

Author of Report: Vicki Low, Moray ASP Consultant Practitioner – HSCM
Kenny O'Brien, Adult Public Protection Lead - NHSG
Background Papers: with author
Ref:

CATEGORY	OUTCOME	TASK	AGENCY	LEAD	PROGRESS	COMP DATE	UPDATES
Policy, Process and Procedures	All practitioners to have a clear understanding of the policy, process and procedures in Moray of Adult Support and Protection	Team Manager oversight and involvement of chairing of all review adult support and protection case conferences, in line with the Operational Guidance, to support clearly defined initial case conference and review case conference process - This will include regular updates and review to ensure collaborative approach - this can be discussed within the fortnightly ASP operational meeting.	Local Authority	CSWO	In Progress	Oct-22	All team managers given opportunity to attend case conferences and to undertake shadowing opportunities since March 2022. Support required to TMs to release capacity to chair meetings.
		Core Group of front line practitioners formed to review Investigation documentation on CF - specific attention to the management of risk and protection planning within recordings	Local Authority	VL	In Progress	Nov-22	Subgroups to commence August 2022
		Core Group of front line practitioners formed to review Screening Tool documentation on CF - specific attention to the management of risk, protection planning and application of the 3-point test.	Local Authority	VL	In Progress	Nov-22	Subgroups to commence August 2022
		Lead agency responsivity to ensure both local and Grampian processes align and continue to be embedded into social work practice. This will be monitored via quality assurance activities and regular briefing sessions. Further work being undertaken on a Grampian-wide basis to align the Grampian Procedures with the revised Codes of Practice and Local Guidance.	Local Authority	VL	In Progress	Jan-23	QA activities underway in the form of screening tool and IRD audits. Revision of the Grampian Procedures being undertaken using a pan-Grampian approach. First draft to be completed end September 2022.
		Core Group of front line practitioners formed to devise, design and implement Large Scale Investigation recording and investigation documentation on Carefirst - attention	Local Authority	VL	In Progress	Nov-22	Subgroups to commence August 2022. Due to LSI activity this activity has been completed by LSI lead Officers and will be reviewed alongside x8 council officers
		Full Review of the Decision Specific Capacity Tool to be undertaken on a multi-agency basis – with input from NHSG and Lead Agency council employed staff.	NHS G	KOB	In Progress	Sep-22	Evaluation to be undertaken in August - one year anniversary of revised tool going live. Adjust, as per feedback.
		Initiate ASP Champions Role within NHSG - ensure that staff have local contacts and links for advice and support - alongside more formal structures.	NHS G	NHSG ASP	In Progress	Nov-22	Scoping begun. NHSG ASP Group has considered initial proposal and has endorsed the concept. Now working out details of implementation.
		iVPD local process review to take place in order to identify opportunities for improvements in quality of information shared, and expectations of agencies receiving Adult Concern Reports from Police.	Police	SMcD	In Progress	Jan-23	activity well underway with multi-agency sub group formed and active discussion and planning taking place
Training and Development	All practitioners within the Moray partnership are sufficiently skilled, confident and knowledgeable about Adult Support and Protection in accordance with their role	Clear training calendar available for external partners to book via Eventbrite	Local Authority	Training Facilitator /training team	In Progress	Oct-22	draft training calendar devised Aug 2022
		Collaboration with Social Work training to facilitate complex risk assessment training across adult social work	Local Authority	Training Facilitator/training team	In Progress	Dec-22	Update July 2022 - Complex Risk Assessment Training designed- to arrange dates to disseminate to staff. Agreement via Grampian group that Complex Risk Training will be a priority of the group moving forward
		Adult Support and Protection Training Plan to be available to all practitioners throughout Adult Social Work, Social Care and 3rd sector	Local Authority	VL	Completed	Aug-22	Training Plan disseminated to all 3rd sector - March 2022. Training Plan available on Moray Protects webpage - April 2022. Training Plan available to all Social Work Teams - April 2022. Training Plan available to all housing and children services - July 2022.
		Collaboration to take place with Child Protection to design and deliver Chronology training across Children and Adult Social Work -	Local Authority	Training Facilitator /VL/EJ	In Progress	Mar-23	Pilot of Multi-Agency chronology in place Dec 2021. Discussion within Grampian Group agreement to propose to take forward Grampian wide with all partners - idea to be presented and agreed at Public Protection Forum July 2022. Update 03-09-2022 - agreement that chronologies will be taken forward Grampian wide
		Clear and up to date records of all Adult Support and Protection training undertaken - Module, 1, 2, 3 and 4 - including when Council Officer refresher training is required	Local Authority	Training Facilitator	In Progress	Jan-23	Spreadsheet underway to evidence training.
		Council Officer Handbook detailing tasks in relation to Adult Support and Protection duties and role	Local Authority	VL	In Progress	Nov-22	currently in draft as of July 2022 - VL to continue to progress
		Develop Practitioner Guidance on Self-neglect and Hoarding	Local Authority	Training Facilitator	In Progress	Nov-22	Draft Guidelines developed - training programme being developed to support.
		Developing a trauma informed workforce factoring in on going discussion and reflection with council officers to monitor changes in practice and to take forward learning	Local Authority	VL/BS	In Progress	Jan-24	Trauma informed awareness session within council officer forum undertaken in Aug 2022. Trauma informed portfolio to be taken forward by BS (requires top-down approach). Discussion to take place within practice governance and a social work sub-group to be formed across adult and child services to take forward.
		Develop a way to analyse training activates to inform the impact of training on Practitioners.	Local Authority	VL/Training Facilitator	Not Started	Mar-23	Initial discussions to take place with Training Facilitator by end September 2022.
		Analysis exercise to take place following training feedback on a 6 monthly basis - used to inform future training events	Local Authority	Training Facilitator	Not Started	Mar-23	Report to be shared by training facilitator at November APC and Council Officer Forum.
		New training framework for ASP to be embedded with all patient facing staff receiving a facilitated level 2 ASP training course.	NHS G	KOB	In Progress	Aug-24	Training framework signed off and approved. Level 2 training now mandatory. Existing staff, being worked through on a 3 yearly renewal cycle of training provision.
		For NHSG staff recording of ASP input and activity - revise ASP Level 2 Training to include specific section on Health records and ASP, good practice examples to be included. Also - practice note to be issued to all professionals regarding Health records and ASP	NHS G	KOB	In Progress	Sep-22	Training curriculum now revised and being delivered. Practice note being drafted - pulling in Clinical Professional Directors for additional weight + linking to profession specific guidance etc. .
		Financial Harm subgroup lead by Police Scotland (John Webster)	Police	JW	In Progress		
		Mandatory online training for ASP rolled out and to be undertaken by all officers.	Police	JL	In Progress		

		Training and briefings to existing and new members (on induction) in relation to their roles and responsibilities on the ASP committee	Multi Agency	APC Chair	In Progress	On going	Training and updates delivered as required
		Implement learning points from Multi-Agency IRD Audit	Multi Agency	VL/Emc/KO/JL	In Progress	Oct-22	IRD report written and presented to APC September 2022. Presented to Council Officer forum September, Further reflection and implementation of learning points to be taken forward at next council officer session - as well as specific
Service Redesign and Review	Clear leadership in Adult Support and Protection	Adult Social Work consultation - design and implementation of a service wide development and improvement plan to reflect on ASP inspection, SDS standards and national and local policy	Local Authority	CSWO	In Progress	Oct-22	Initial discussions have taken place with Team Managers with regard to important of improvement and development for Social Work. Consultation Workshops planned for end Sep 2022.
		To develop a multi-agency approach and training for 2nd persons in Adult support and protection	Multi Agency	VL/KOB/JL/PM	Not Started	Dec-22	Ongoing developmental sessions with a view to implement improved integrated working to support positive outcomes . Plan to commence first session post ASP Inspection -Agreement at Grampian working group for awareness raising
		ASP Live Event - September/October 2022	Multi Agency	VL/KOB/JL/PM	In Progress	Oct-22	
		Discussion to take place within COG and APC regarding capacity and gaps in service to ensure clear oversight of matters by our more senior leaders.	Multi Agency	VL/KOB/JL/PM	In Progress	On going	discussions taking place at both COG and APC regarding gaps and capacity issues. This is also reflected within our APC Risk Register and is a standing item agenda
ICT and Recording	Processes clearly defined within ICT recording systems with clear performance indicators set and adhered to.	All adult support and protection files to be transferred to Every Client Documents within T drive	Local Authority	ASP Admin/ICT	In Progress	Mar-23	work is underway - however, this is a large task and requires clear planning with ICT to achieve due to the volume of work
		Naming convention in place for all Adult Support and Protection electronic files	Local Authority	VL	In Progress	Mar-23	Naming convention written and out to teams (February 2022). assurance work to take place to ensure consistent approach is used. Once all client information is transferred to every client documents then this will be easier to monitor.
		Information and Intelligence Subgroup to analyse data set and to improve standard of reporting to COG, APC and risk and performance management group	Local Authority	VL/AK/BW	In Progress	Dec-22	ToR to be written and presented to APC in September 2022. use of Pentana systems in place
		Procedure in place for use of events/activities in relation to Adult Support and Protection activity on CF	Local Authority	V Logan/VL	In Progress	Dec-22	Recording of duty to enquire, investigation and review all within CF events - completed Aug 2021. Ongoing work undertaken with regard to quality of recording to continue
		Use of Pentana to measure progress of multi-agency improvement plan.	Local Authority	ASP Admin/VL	In Progress	On going	Pentana is updated following every 6 week improvement and planning meet. Pentana reminds of tasks to be completed - improving oversight.
		Discussions to take place regarding proposal for a possible Data set from Police Scotland which would be added to the existing local data set to APC.	Police	JL	In Progress		JL 20/07/22 - Proposal to be discussed with Sheila McDermot, Concern Hub Manager.
Professional Practice	Practitioners to feel supported in their professional practice	Regular Council Officer Forums - to include regular feedback sessions	Local Authority	Emc/SG	In Progress	On going	Council Officer Forums in place. Formally recorded and training materials to be available within SharePoint for CO viewing - TO be reviewed Nov-22 by consultation with CO's
		Regular Team Manager 'catch up' meetings to take place to discuss adult support and protection practice within teams	Local Authority	VL	Not Started	Oct-22	Discussion to take place Aug-22 with team managers to agree regular 'catch up' sessions to discuss practice within teams and provide collaborative approaches to sharing good practice and highlighting areas of improvements
		To provide ongoing mentoring and support for Social Work Council Officers undertaking ASP activity.	Local Authority	EMcD	In Progress	On going	Training delivered to Council Officers delivered in October - December 2021 . Additional refresher training in March 2022. Rolling programme established. Ongoing mentorship of Council Officers taking place with tasking documents in place
		Review across all patient facing areas that professional supervision is offered/available and that ASP is a clearly identified area for regular discussion [ensure this is captured in any NHSG policy/procedures/guidance].Ensure specific ASP clinical/professional supervision is offered to staff who are actively working with adult protection cases	NHS G	NHS G ASP	In Progress	Sep-22	Scoping complete + managers/staff now have ASP as a regular item on 1:1's and supervision discussions. Also a regular item now on team meeting agendas. NHSG Public Protection Supervision arrangements now drafted - 1st draft complete and being consulted on.
		"Review local practice to ensure that key agency professionals feel comfortable and have suitable agency contacts for early discussions around adult protection matters, thus promoting inter-agency peer-to-peer support." .	Multi Agency	JL	In Progress	Dec-22	CP ASP, Police and Health leads all have good collaborative relationships - all to discuss and agree how this may be mirrored for practitioners - JL to take forward.
Lived Experience	All adults at risk are able to have their views fully represented	Review commissioned advocacy service to ensure formal advocacy services are as accessible as possible for people involved in ASP process	Local Authority	TW	Delayed	Mar-23	VL on project team for commissioning needs document. Meetings with advocacy on a monthly basis. Commissioning extension for 18mths
		Listen to People - Agree and implement a systematic approach to capturing the lived experience (qualitative) of people who have been in contact with the ASP process	Local Authority	APC Chair	In Progress	Review quarterly	APC subgroup - Hear Me, established March 2022. Communication and Engagement Plan produced and being implemented by Advocacy. Report to be produced for Nov APC
	Good quality	Design of an ASP journey audit tool with the intention to undertaken monthly Case File Audit to take place for 1x adult subject to the Adult Support and Protection process. This will encompass from point of referral to Initial Case Conference and findings shared with Practice Governance Board and reported to APC with the aim to inform practice improvements and highlighting elements of good practice.	Local Authority	VL/BS/JG	Not Started	Feb-23	Discussion to take place with BS and JG to commence designing journey audit tool by Aug-22
		Involvement of Team Managers in undertaking Investigation documentation quality assurance exercise on a monthly basis - to evaluate practice - feedback and further	Local Authority	VL	Not Started	Nov-22	VL to discuss with Team Managers following agreement from Investigation document subgroup on changes to current document - monthly assurance

Quality Assurance and Audit	assurance work takes place to ensure consistency and competency and to inform future improvements	Involvement of Advanced Practitioners across Adult Social Work in adult support and protection quality assurance activities for monthly single agency screening tool audits	Local Authority	EMcD/VL	In Progress	Oct-22	EMcD is currently engaging with all Advanced Practitioners in undertaking quality assurance tasks on a monthly basis - 5 screening tool documents are audited to look at quality of documentation. Agreement that the outcomes of findings will be shared with practitioners and teams to further improve practice
		Audit of screening tool documentation (5 per month from Jan - June 2022) to be undertaken and reported to APC.	Local Authority	VL	In Progress	Oct-22	Audits inputted, report to be compiled for November APC
		Involvement of Consultant Practitioners in single agency auditing IRDs on a monthly basis - feedback sessions for Social Work teams to be factored into this - with further	Local Authority	VL	In Progress	Oct-22	Tool developed, audit to be undertaken - to commence October 2022
		Multi-Agency case conference table audit to be undertaken with learning to be disseminated.	Multi Agency	VL/KOB/JL	In Progress	Feb-23	Tool developed, audit to be undertaken.
		Multi-Agency IRD Summary Quality Assurance Audit to take place - review all IRDs from commencement	Multi Agency	VL/KOB/JL	In Progress	Jul-22	Audit completed, report to be finalised and presented to APC. Update 03-09-2022 IRD report compiled and presented to APC 02-09-2022. Learning to take

REPORT TO: **CLINICAL AND CARE GOVERNANCE COMMITTEE ON 27 OCTOBER 2022**

SUBJECT: **CLINICAL AND CARE GOVERNANCE UPDATE**

BY: **CHIEF NURSE – MORAY**

1. REASON FOR REPORT

1.1. To provide an update to the Clinical and Care Governance Committee of the developments in relation to clinical and care governance and the intention to hold a further workshop.

2. RECOMMENDATION

2.1. It is recommended that the Committee:

i) considers and notes the content of this report and the associated action plan (APPENDIX 1);

ii) acknowledges the delay in the provision of the workshop due to changes in senior personnel and the impact of the Covid-19 pandemic; and

iii) notes that an update will be provided in four months' time.

3. BACKGROUND

3.1. The national Clinical and Care Governance Framework 2013 provides Integration Authorities with an overview of the key elements and principles that should be reflected in the clinical and care governance processes implemented by Integration Authorities.

3.2. To fulfil this requirement there is a need for Moray Integration Joint Board (MIJB) and Health and Social Care Moray (HSCM) to ensure that they provide assurance that effective arrangements are in place to ensure there is:-

- Relevant Health and Social Care professionals held accountable for standards of care provided.
- Effective engagement with communities and partners and improved health and wellbeing outcomes are being met.

- Effective scrutiny of the quality of service performance to inform improvement priorities.
- Clear learning and improvements generated from effective systems.
- Support for staff if concerns are raised relating to safe service delivery.
- Clear lines of communication and professional accountability from point of care to Executive Directors and Chief Professional Officers accountable for clinical and care governance.

3.3. A Clinical and Care Governance workshop was held in Elgin on 8 January 2020, the output reported to this committee on 27 February 2020 (para 9 of the minute refers) and a progress update on the finalised action plan provided on 25 February 2021 (para 7 of the minute refers.) Two of the five key themes of areas for improvement identified by the workshop were to:

- Declutter and simplify the existing reporting mechanisms and provide clarity for accountability and responsibility
- Seek clarification from NHS Grampian, Moray Council and professional leads of their assurance requirements.

3.4. A report to Committee in February 2022 detailed the governance arrangements during the response to Covid-19, provided an update on progress against the action plan and proposed a follow up workshop for April / May 2022. This workshop did not take place on the proposed timescale due to staff changes throughout the clinical and care governance team.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. HSCM are currently appraising the 2020 Clinical and Care Governance Action Plan to determine progress so far and future direction.

4.2. Progress has been made but since that time new key stakeholders are now in place and must be engaged in order for HSCM to move forward with actions.

4.3. Further scoping work is required with departments to determine the new priorities and Key Performance Indicators.

4.4. The intention is to pull current / new stakeholders into a consultation workshop to ensure all leaders within the partnership have an understanding of the clinical and care governance framework and requirements going forward.

4.5. The aim of the full workshop is to include / discuss the following proposed points. These will be refined at the consultation workshop:

- Overview of Groups/Committees – what is needed and why
- How can HSCM evidence what is being requested
- How can this be linked to Health and Social Care standards
- To raise awareness of and strengthen the governance framework
- To discuss meeting structure and terminology used
- Discuss and confirm trends to report on – for example, Tissue Viability, Mental Health
- Roles and responsibilities including ownership
- Escalation process – to ensure a clear and consistent process
- Process to share learning

- Training

4.6. Consideration required with regards to changes to governance for services and systems which must be incorporated – namely Children & Families and Justice Social work.

4.7. Key stakeholders also need to consider the impact of the National Care Services Bill and the required changes which will need to be incorporated under the auspices of this Bill.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"
Governance arrangements are integral for the assurance of the delivery of safe and effective services that underpins the implementation of the strategic plan.

(b) Policy and Legal
The Public Bodies (Joint Working) (Scotland) Act 2014 requires Health Boards and Local Authorities integrate adult health and social care services. This paper outlines the work being undertaken to ensure that the clinical and care governance framework for HSCM and partners, provides a clear understanding of the contributions and responsibilities of each person and how these are integrated.

(c) Financial implications
There are no financial implications arising as a direct result of this report.

(d) Risk Implications and Mitigation
The work that is being undertaken to improve the links between stakeholders and clarify the governance framework will further strengthen provision of assurance and reduce the likelihood of negative impacts to the system.

(e) Staffing Implications
There are no staff implications arising as a direct result of this report.

(f) Property
There are no property implications arising as a direct result of this report.

(g) Equalities/Socio Economic Impact
An Equality Impact Assessment is not required because there are no changes to policy as a result of this report.

(h) Climate Change and Biodiversity Impacts
No climate change or biodiversity implications have been determined for this report.

(i) Directions
There are no directions required as a result of this report.

(j) Consultations
Consultations have taken place with Head of Clinical Governance and members of the Clinical and Care Governance Group and their comments have been incorporated in the content of this report.

6. CONCLUSION

6.1 The committee are asked to acknowledge the challenges imposed on the implementation of the clinical and care governance action plan created by the Covid-19 pandemic, including the redeployment of key personnel to frontline services. As noted a number of key stakeholders have changed posts and further engagement is required with new staff to move the agenda forward.

Author of Report: Jacqui Shand, Clinical Governance Co-ordinator (Moray HSCP)
Background Papers: with author
Ref:

Clinical Care and Governance Development Aim: -

To design and implement a streamlined assurance framework, that embeds clinical and care risk management, improvement and assurance across our integrated system and provides safe, effective and person centred care. This action plan was determined through the translation of ideas generated at the workshop on 8 January 2020. This action plan and subsequent progress will be reported to Clinical and Care Committee. To fully progress these actions will require involvement with a wide variety of stakeholders from Health and Social Care Moray staff, NHS Grampian and Aberdeenshire and City HSCP, Professional Leads and Clinical Care Governance Committee.

Since this process was initiated in January 2020, significant disruption has occurred as a result of the Covid-19 Pandemic. The pandemic has led to the redeployment of key staff and resource to other roles and although attempts have been made to restart the process as is, again there has been further disruption.

At this time a full Clinical Governance team is now in place and will remain so over the next 12 months. As a result it is proposed that this project be reviewed, restarted and fully completed and implemented within that 12 month period, i.e. by end September 2023. The following Action Plan outlines this 12 month programme.

	Required Action	Progress	Update	Lead	Timescale
	Phase 1 - Review and Plan				
1	Gap Analysis of previous change process, completed actions, relevance of completed actions in order to determine current relevance. *Output – New Action Plan*	Completed	Both review of previous plan and consultation with previous teams complete	Elizabeth Tait / Jacqui Shand / Isla Whyte	Completed
2	Gap Analysis of current data management processes. *Output – Dashboards and data communication process*	Advanced and ongoing with design phase initiated	Being reviewed and undertaking now – output of meetings variable	Jacqui Shand	By end December2022
3	Gap Analysis and audit of current processes, policies and procedures. *Output – identification of those procedures which require upgrading, where process is*	Advanced and ongoing	Many processes are in draft form and parts of these are now not fit for purpose following pandemic.	Elizabeth Tait / Jacqui Shand / Isla Whyte	By end December 2022

	required, training requirements, ongoing audit requirements.				
4	Review current standards and anticipate imminent regulatory changes in relation to the formation and structure of HSCP's	ongoing	Under review	Elizabeth Tait / Jacqui Shand	By End of December 2022
5	Undertake a Review of National Good Practice	ongoing	Under Review esp. in relation to up and coming changes to legislation	Elizabeth Tait / Jacqui Shand	By End of December 2022
6	Undertake a review of Covid learnings and positive changes, both within Grampian and in the wider service - to be taken forward and integrated into the ongoing Clinical Governance Framework	ongoing	Scheduled for Workshops	Elizabeth Tait / Jacqui Shand	By End of December 2022
	Phase 2 – Design				
1	Create draft framework based on current framework, integrating updated information	Begun	On track	Clinical Governance Team / Consultation	End March 2022
2	Create draft data flow map, dashboard design, data collection points and accompanying overarching process of managing and auditing the collection and communication of critical data in relation to the recognition, quantitative and qualitative interpretation and escalation of Clinical Risk within the organisation	To be initiated	On track	Clinical Governance Team / Consultation	End March 2022
3	Create refreshed organogram, with roles and responsibilities relating to job function	To be initiated	On track	Clinical Governance Team / Consultation	End March 2022

	rather than person to identify accountability and responsibilities throughout the organisational hierarchy.				
4	Training matrix design to identify training requirements for HSCP team – to be integrated into appraisal structures The main themes have been identified: 1. Dashboards / data requirements/ new kpi's / Datix 2. Root cause analysis 3. Design and application of organisational controls	To be initiated	On track	Clinical Governance Team / Consultation	End March 2022
5	Design and timetable series of workshops throughout the next 12 months to consult and communicate to the HSCP team in order to facilitate ongoing upskilling and implementation of new framework	To be initiated	On track	Clinical Governance Team / Consultation	End March2022
	Leadership Workshop 1 Senior Management Team review and consultation carried out on proposed structure. The first workshop comprises of i. a review of all process drafts and full consultation on new ii. Identification of Leadership roles, responsibilities and actions throughout the project to implement new structure to build a culture of consensus and strong leadership on the future model – ONE HSCP structure	To be initiated	On track	Clinical Governance Team / Heads of service / Senior management teams	February 2022

	rather than the current divided NHS vs Council dialogue				
	Implementation				
1	**Workshop 2** Full Service Introduction of new structure expectations and tools i. Roll out dashboards, kpi's to collect data from January 2023 ii. Present HSCP unified clinical governance management processes, policies and procedures iii. Management of Clinical governance – required meetings and data sharing	To be initiated	On track	Clinical Governance Team	May / June 2023
2	Implement renewed system of meetings	To be initiated	On track	Service managers	May / June 2023
3	Implement new system of data collection utilising dashboards and working to kpi's	To be initiated	On track	Service Managers	May / June 2023
4	Ongoing monitoring to snag issues and training requirements throughout the roll out period – Conducted through ongoing reflective practice and open door processes to collect positive feedback and innovation from staff at all levels	To be initiated	On track	Clinical Governance Team	May - Ongoing 2023
5	Two weekly senior management / heads of service meetings – short progress meetings with very limited agendas designed	To be initiated	On track	Clinical Governance Team / Heads of Service	May - Ongoing 2023

	specifically to snag any issues during the project implementation phase				
	Review				
1	Implement improved and robust systems for monitor and review of the process to ensure new systems are maintained and subject to continual improvement processes – audit diary	To be initiated		Clinical governance team / service managers	Initiate January 2023
2	Harvest data from improved systems of trapping and monitoring positive outcomes and learnings from within the clinical governance framework to imbed shared learnings across the HSCP – Building positive behaviour spirals – through meeting structures	To be initiated		Clinical governance team / service managers	Initiate January 2023
3	Ongoing staff appraisals – to ensure ongoing competency	To be initiated		Clinical governance team / service managers	Initiate January 2023
4	Sequence of three further workshops throughout the rest of 2023 in order to imbed and normalise new practices and build competency	To be initiated		Clinical Governance Team	Initiate January 2023
5	Annual Review workshop for HSCP Leadership Team – To review legislation, best practice, the last year's performance of the system, kpi setting.	To be initiated		Clinical Governance Team / Heads of Service	January 2024

REPORT TO: **CLINICAL AND CARE GOVERNANCE COMMITTEE ON 27 OCTOBER 2022**

SUBJECT: **COMPLAINTS REPORT FOR QUARTER 2, 2022/2023**

BY: **CHIEF NURSE, MORAY**

1. REASON FOR REPORT

1.1. To inform the Committee of complaints reported and closed during Quarter 2 (1 July 2022 – 30 September 2022).

2. RECOMMENDATION

2.1. It is recommended that the Committee considers and notes the totals, lessons learned, response times and action taken for complaints completed within the last quarter.

3. BACKGROUND

3.1. Within HSCM, complaints received by NHS Grampian (NHSG) and Moray Council are recorded on 2 separate systems, in accordance with the appropriate policy and procedure of these organisations.

3.2. At the meeting on 27 February 2020 (para 7 of the minute refers), it was agreed that a combined report from NHSG and Council complaints systems be submitted to future meetings of the Committee. At the Committee meeting on 27 August 2020 (para 14 of the minute refers) it was requested that the procedures be explained to demonstrate the similarities and differences, if any.

3.3. NHS and Local Authority Complaint Handling Procedure/Policy requires all staff to deal with feedback and complaints in a person/client-centred way. The procedure has been developed working closely with the Scottish Public Services Ombudsman (SPSO). There is a standard approach to handling complaints across the NHS and Local Authority, which complies with the SPSO's guidance on a model complaints handling procedure and meets all of the requirements of the Patient Rights (Scotland) Act 2011, and accords with the Healthcare Principles introduced by the Act.

3.4. The complaints process followed by both NHSG and Moray Council have the same target response timescales. Early resolution, or front line, complaints will be responded to within 5 working days and complaints handled at the

investigation stage have a response time of 20 working days. Where it is not possible to complete the investigation within 20 working days an interim response should be provided with an indication of when the final response should be provided.

3.5. The decision as to whether the complaint is upheld or not will be made by the manager or Head of Service. If the person raising the complaint is not satisfied with the outcome then they many contact the Scottish Public Services Ombudsman (SPSO) for an independent review and assessment, however prior to this, every effort is made to engage with the complainant to resolve the matter to their satisfaction.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The CCG Committee is presented with quarterly complaints performance information using the mandatory Key Performance Indicators (KPIs), published by SPSO in March 2022. These are:

Indicator One	**The total number of complaints received** *The sum of the number of complaints received at Stage 1 (this includes escalated complaints as they were first received at Stage 1), and the number of complaints received directly at Stage 2.*
Indicator Two	**The number and percentage of complaints at each stage which were closed in full within the set timescales of five and 20 working days** *The number of complaints closed in full at stage 1, stage 2 and after escalation within MCHP timescales as % of all stage 1, stage 2 and escalated complaints responded to in full*
Indicator Three	**The average time in working days for a full response to complaints at each stage** *The average time in working days to respond at stage 1, stage 2 and after escalation*
Indicator Four	**The outcome of complaints at each stage** *The number of complaints upheld, partially upheld, not upheld and resolved at stage 1, stage 2 and after escalation as % of all complaints closed at stage 1, stage 2 and after escalation*

4.2 The qualitative indicator on learning from complaints has been removed. However, Part 4 of the SPSO Model Complaints Handling Procedure on Governance stresses the importance of learning from complaints, and the requirements to record and publicise learning. Therefore learning from complaints will be continue to be included in quarterly complaints performance reports and annual complaints reports.

4.3. HSCM Complaints performance data for Quarter 2 is attached at **Appendix 1**.

4.4. Information about complaints referred to the Ombudsman are also included along with any complaints relating to the actions and processes of Moray Integration Joint Board.

4.5. Figures reported do not include complaints raised regarding the vaccination appointments or processes as these are being dealt with through a dedicated team covering the Grampian area.

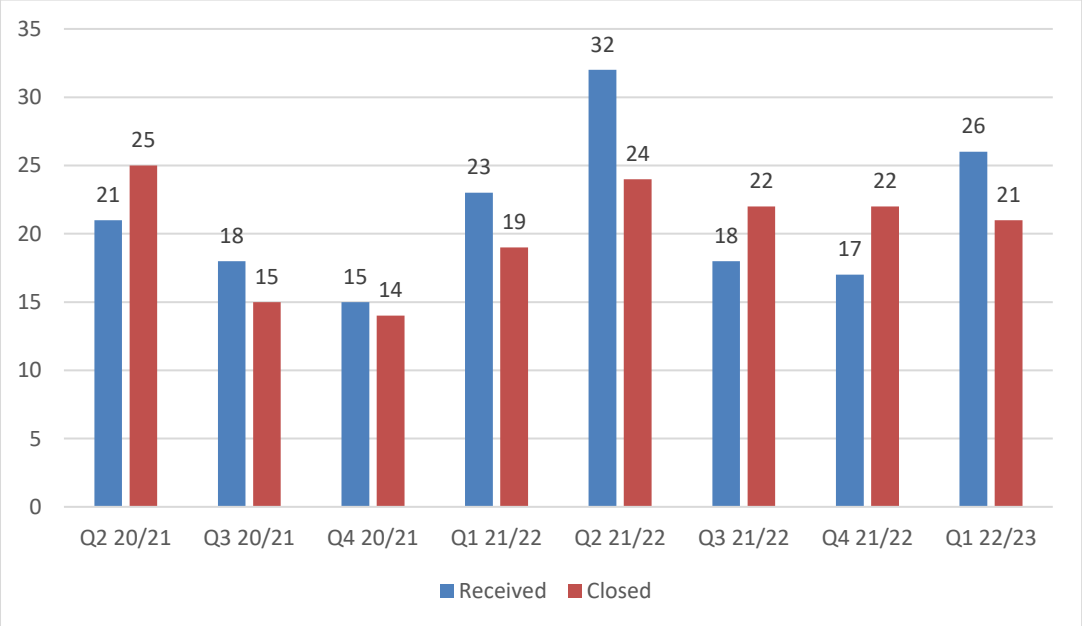
4.6. Overall, a total of 33 complaints were received during Quarter 2.

	Total Received in Quarter 2	**Total Closed in Quarter 2**
Local Authority	7	5
NHS	26	16
	33	**21**

4.7. Two of the complaints received by NHS during Q2 were closed as the necessary consent form was not received. When the remaining 24 complaints have been concluded more detail can be reported to the next Clinical and Care Governance Committee in terms of a reason for the potential spike in complaints received (between 14 and 17 NHS complaints were received in each of the last 3 quarters).

4.8. Of the 16 NHS complaints recorded as closed during Q2, 1 was withdrawn by the complainant, 2 were closed as consent was not received and 1 was closed as it was a duplicate record.

4.9. The table below sets out HSCM complaints received and closed by Quarter:



4.10. There were 9 MP/MSP enquiries received and recorded on the Council system, Lagan, under HSCM. These were allocated as follows:

Service	Number of Enquiries
Care at Home	4
Occupational Therapy	1
Access Team	4

4.11. Enquiries have been received from MPs/MSPs and Councillors direct to managers in HSCM, at this stage it is not possible to accurately report on numbers received due to these enquiries not all being logged centrally. It can be noted enquiries were about a variety of matters with not one topic standing out more than others in terms of recurring themes. Processes for recording these appropriately are currently being defined to support effective feedback, prevent duplication and aid identification of trends and learning for all services. This work has been delayed due to staffing changes.

4.12. Any complaints received from MP/MSPs on behalf of constituents are recorded on Datix and captured in the data provided at **Appendix 1**.

4.13. Two concerns were received and closed during this reporting period, both recorded on Datix. One was from a MSP on behalf of constituent and the other direct from a member of the public.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

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

Effective handling of complaints is used to ensure the efficient and sustainable delivery of services to meet priorities.

(b) Policy and Legal

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

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

There are systems and processes in place across service areas to support clinical governance, providing assurance to the HSCM Senior Leadership Team and to the Clinical and Care Governance Committee. There are platforms within Health and Social Care to discuss and share good practice, learning and challenges.

Moray Integration Joint Board (MIJB), Moray Council and NHS Grampian could find themselves exposed to significant risks if good governance is not in

place. The purpose of this report is to oversee the processes to ensure that appropriate action is taken in response to adverse events, scrutiny reports/action plans, safety action notices, feedback, complaints and litigation, and those examples of good practice and lessons learned are disseminated widely.

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

(f) Property
None directly arising from this report.

(g) Equalities/Socio Economic Impact
Not required as there are no changes to policy.

(h) Climate Change and Biodiversity Impacts
None directly arising from this report.

(i) Directions
None directly arising from this report.

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

- Corporate Manager
- Tracey Sutherland, Committee Services Officer, Moray Council
- Clinical and Care Governance Group

6. CONCLUSION

6.1. This report provides a summary of HSCM complaints received and closed during Quarter 2 (1 July – 30 September 2022). The governance and monitoring of complaints forms part of core business for teams and services and the provision of a good quality, effective and safe service is a key priority for all.

Author of Report: Isla Whyte, Interim Support Manager
Background Papers: with author
Ref:

APPENDIX 1

Complaints Data (by closed complaints)

Quarter 2 (01/07/22 – 30/09/2022)

Learning from complaints

Teams and services actively review the outcomes of complaints to see where improvements can be made and learn from the feedback, with a view to reducing the number of complaints in future. The tables 1, 2, 3 and graph 1 below set out the stages the complaints were closed and what the complaint was about and what action taken.

Table 1

Complaints Information Extracted from Datix – Actions Taken/Outcome of complaints **closed** during Quarter 2, 2022/23

	Fully upheld: Complaint is accepted	Partially upheld: Complaint is partly accepted	Not upheld: Complaint is not accepted	Complaint withdrawn: Complaint not taken forward	No value	Total
Communication - Improvements in communication staff-staff or staff-patient	2	5	0	0	0	7
No action required	0	0	4	1	0	5
Share lessons with staff/patient/public	0	1	0	0	0	1
Waiting - Review of waiting times	0	1	0	0	0	1
No value	0	0	1	0	3	4
Total	2	7	5	1	3**	18*

**Figure more than total number of closed complaints as there could be multiple actions taken for each complaint*

*** no value recorded as 2 complaints were closed due to no consent being received and 1 was a duplicate record*

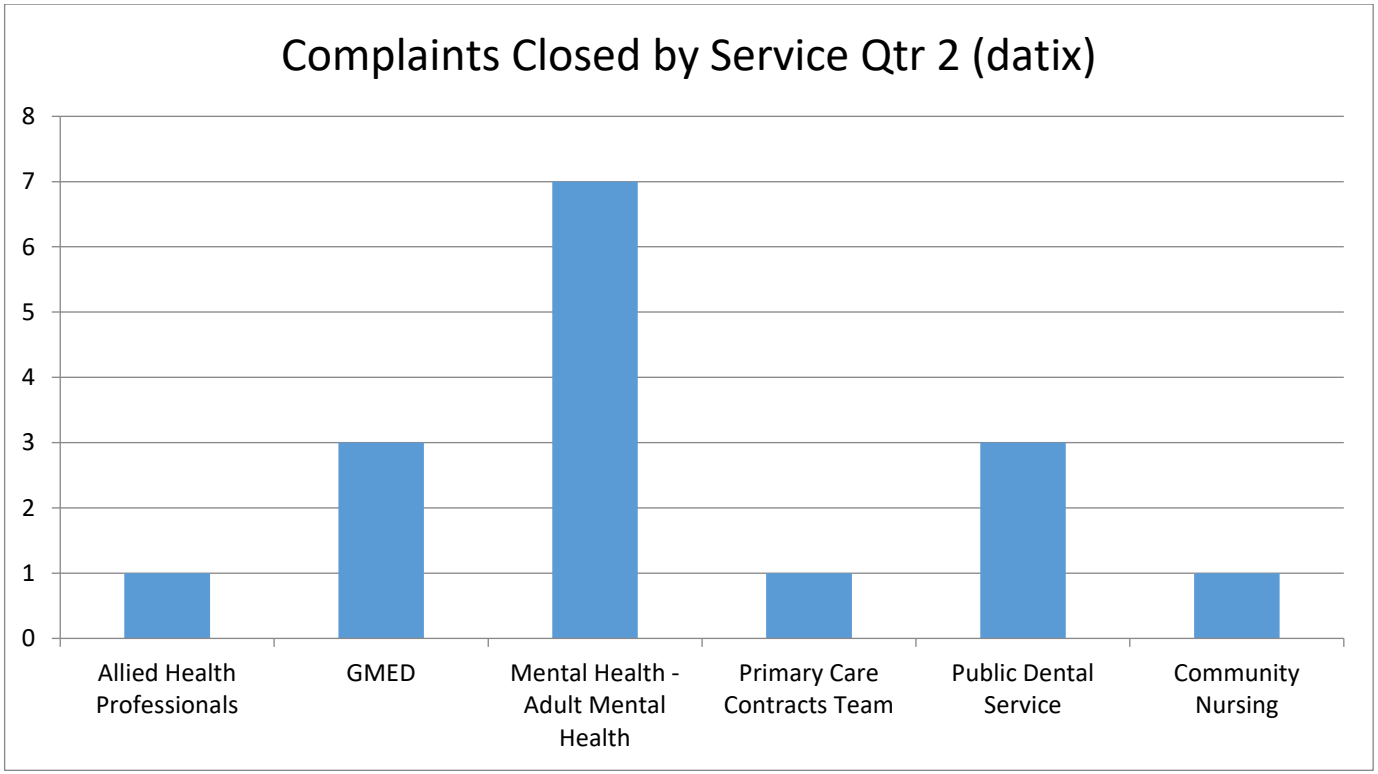
Table 2

Complaints Information Extracted from Lagan:

5 complaints were **closed** during Quarter 2, 2022/23.

Directorate	Department	Service	Upheld	Partially Upheld	Not Upheld	Resolution	Grand Total
Health and Social Care Moray	Health and Social Care Moray	Access Team	0	0	1	0	1
		Care at Home	0	0	1	0	1
		Mental Health	0	1	0	0	1
		Occupational Therapy	0	1	0	1	2

Graph 1



Due to the low numbers it is not possible to detail what the complaint was about as this could lead to patient identifiable information being reported.

Table 3

Complaints Information Extracted from Datix – Action Taken by Service (complaints **closed** during Quarter 2, 2022/23)

	Allied Health Professionals	GMED	Mental Health - Adult Mental Health	Primary Care Contracts Team	Public Dental Service	Community Nursing	Total
Communication - Improvements in communication staff-staff or staff-patient	1	2	4	0	0	0	7
No action required	0	0	1	0	3	1	5
Share lessons with staff/patient/public	0	0	1	0	0	0	1
Waiting - Review of waiting times	0	0	1	0	0	0	1
No value	0	1	2	1	0	0	4**
Total	1	3	9	1	3	1	18*

**this figure does not represent number of complaints closed*

***no value as complaint either withdrawn or no consent received*

Active review of complaints through reporting and investigation is a useful tool to identify learning and improve services. Below are some of the actions and learning from recent complaints.

Actions and Lessons Learned (datix)

Communication	Reminder of accurate information sharing between staff to avoid delays.
	Liaise with ED department to ensure patients can be assured they are expected from GMED service
Education / training / share lessons learned	Share lessons with staff to ensure room towels and laundry are removed promptly from bedrooms.
	Share safety brief with staff regarding routine cleaning of COVID positive areas
	Staff reminded of appropriate use of PPE
	Arrange awareness training for security team regarding medical conditions

Learning Outcome (lagan)

- Outstanding invoices to be sent to support manager to cross reference to reduce any potential delays

Indicator 1 **– The total number of complaints received**

The sum of the number of complaints received at Stage 1 (this includes escalated complaints as they were first received at Stage 1), and the number of complaints received directly at Stage 2.

Table 4 – Total number of complaints **received** in Quarter 2, 2022/23

System recorded	Early Resolution / Frontline	Investigation	Not Marked	**Total**
NHS - Datix	6 marked early resolutions	19 marked investigation	**0**	**25**
Moray Council - Lagan	**3** marked frontline	**2** marked investigative	**2** not yet marked	**7**
Total	**9**	**21**	**2**	**32**

Table 5 – Allocation of complaints **received** in Quarter 2, 2022/23

NHS Service - Datix	
Public Dental Services	2
Community Nursing	3
GMED	10
Out of Hours (Excluding GMED)	1
Mental Health – Adult Mental Health	6
MacMillan Nursing Service	1
AHP	1
Cross Service	1
Total	**25**

Table 6 – Allocation of complaints **received** in Quarter 2, 2022/23

MC Service - Lagan	
TMC Specialist Unit	1
Care at Home	2
Occupational Therapy	3
Mental Health	1
Total	**7**

Indicator 2 **- The number and percentage of complaints at each stage which were closed in full within the set timescales of five and 20 working days**

The number of complaints closed in full at stage 1, stage 2 and after escalation within MCHP timescales as % of all stage 1, stage 2 and escalated complaints responded to in full

There were **16 Complaints closed** on the NHS system Datix during Quarter 2, 2022/23 – breakdown as follows:

Early Resolution – 2

Investigation – 14 (1 was withdrawn by complainant, 2 were closed as consent not received, 1 closed as duplicate record)

No complaints were escalated

There were **5 Complaint closed** on the MC system Lagan during Quarter 2, 2022/23 – breakdown as follows:

Frontline – 5

Investigation – 0

No complaints were escalated

Table 7 – number and percentage of complaints at each stage closed within timescales **(based on complaints closed during Quarter 2, 2022/23)**

	Frontline/Early Resolution within timescale	Investigation within timescale
NHS - Datix	2 out of 2 (100%)	3 out of 10 (30%)
Moray Council - Lagan	1 out of 5 (20%)	N/A

Whilst HSCM aim to respond to complaints within timescales this is not always achievable.

Complaints received into Datix are often multi-faceted and include more than one service across NHS Grampian and other sectors, which can impact on response times due to the level of investigation and coordination required.

Indicator 3 **- The average time in working days for a full response to complaints at each stage**

Table 8 – *average time in working days to respond at stage 1, stage 2 and after escalation* **(based on complaints closed during Quarter 2, 2022/23)**

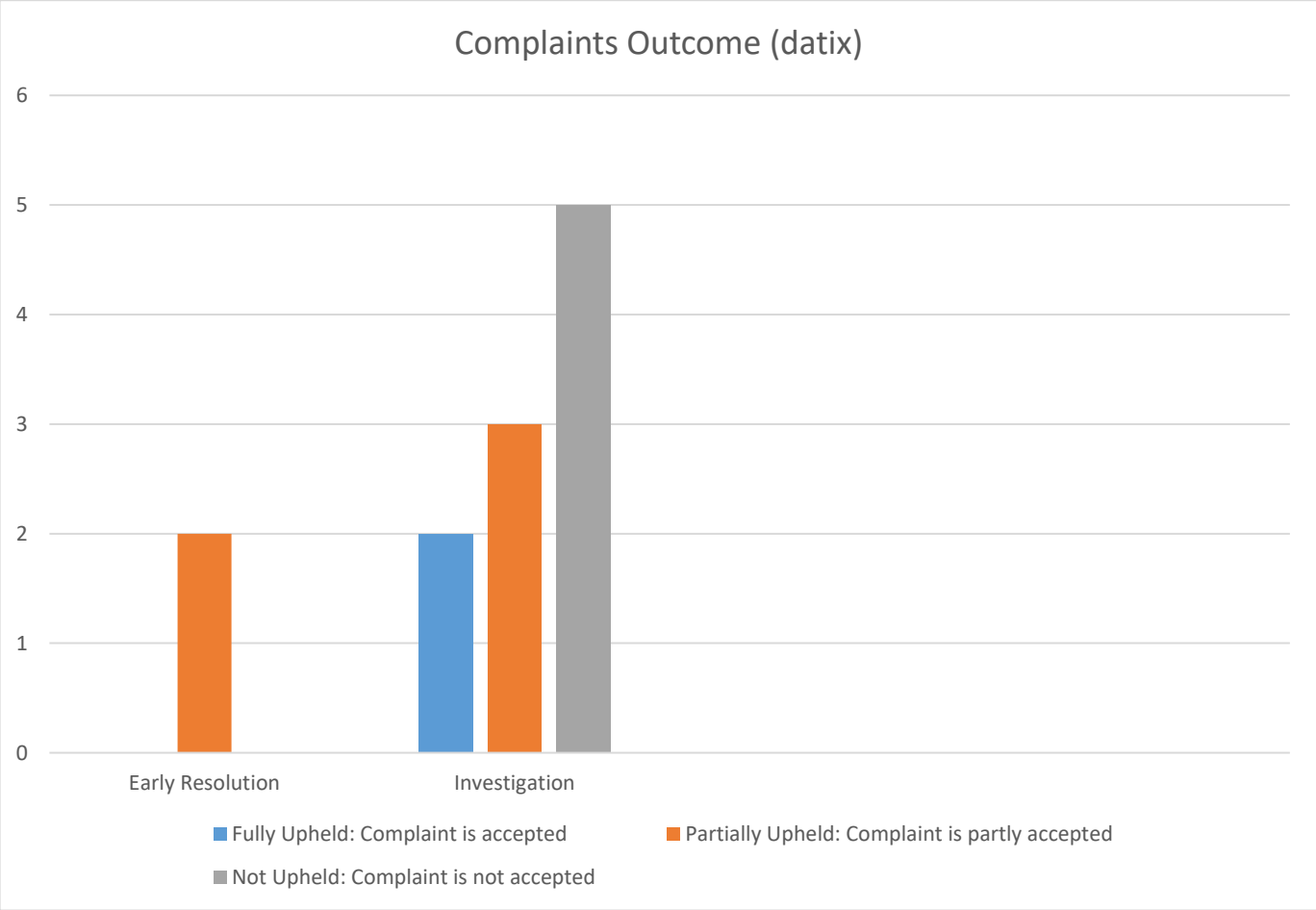
	Frontline	Investigative
NHS - Datix	4 days	36 days
Moray Council - Lagan	10 days	n/a

Indicator 4 **- The outcome of complaints at each stage**

The number of complaints upheld, partially upheld, not upheld and resolved at stage 1, stage 2 and after escalation as % of all complaints closed at stage 1, stage 2 and after escalation

Graph 2 below shows the amount of complaints fully upheld, partially upheld and not upheld as recorded in Datix during Quarter 2, 2022/23. Out of 16 closed complaints on the system 1 was withdrawn by complainant, 1 was a duplicate and 2 consent was not received.

From the remaining 12 complaints closed during Quarter 2 - approximately 16.6% were upheld, 41.6% were partially upheld and 41.6% were not upheld

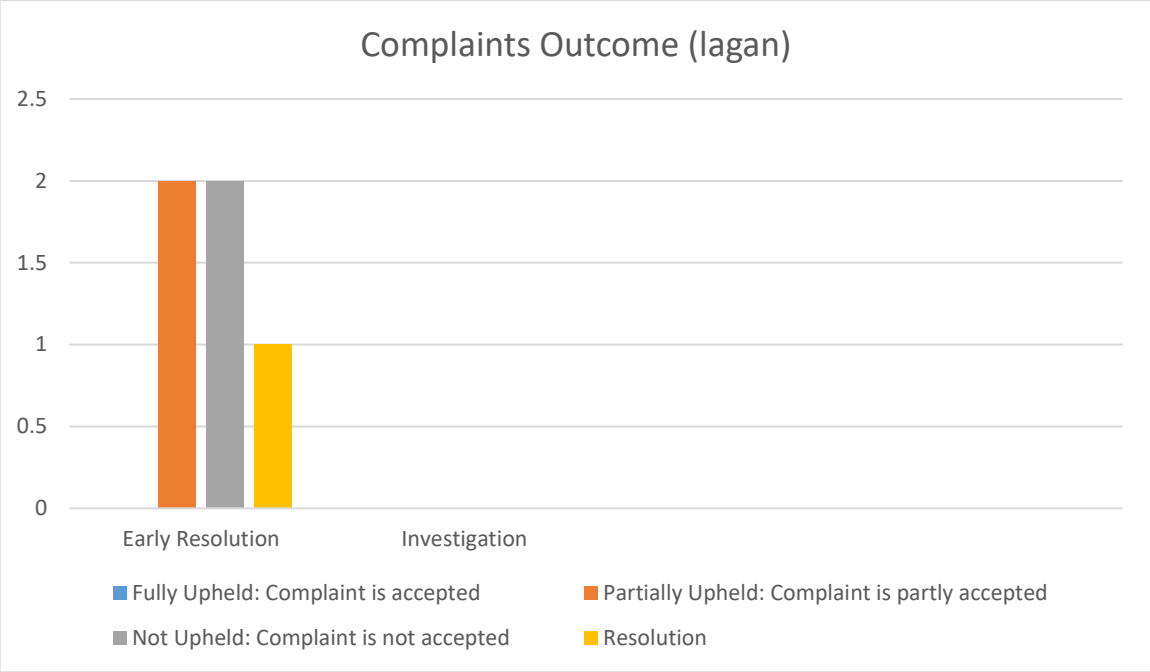


Complaints Information Extracted from Lagan:

5 complaints were **closed** during Quarter 2, 2022/23: **1** was resolved and from the remaining **4 closed**: **50% were partially upheld and 50% were not upheld.**

There were 0 Fully Upheld complaints.

Graph 3 below shows the amount of complaints upheld, partially upheld, not upheld and resolved as recorded in Lagan from the **5 closed** complaints during Quarter 2, 2022/23.



REPORT TO: **CLINICAL AND CARE GOVERNANCE COMMITTEE ON 27 OCTOBER 2022**

SUBJECT: **DRAFT HEALTH AND SOCIAL CARE MORAY ANNUAL COMPLAINTS REPORT 2021/22**

BY: **CHIEF NURSE, MORAY**

1. REASON FOR REPORT

1.1. To provide the Committee with the Draft Health and Social Care Moray (HSCM) Annual Complaints Report for 2021/22.

2. RECOMMENDATION

2.1. It is recommended that the Clinical and Care Governance Committee:

i) consider and note the contents of the annual report; and

ii) submit the draft HSCM Annual Complaints report to MIJB in November for approval prior to publication

3. BACKGROUND

3.1. The first HSCM Annual Complaints Report (2020/21) was published at the end of September 2021 and can be found on the HSCM website https://hscmoray.co.uk/complaints.html

3.2. The annual report summarises and builds on the quarterly reports produced for Clinical and Care Governance Committee. It includes details of the numbers and types of complaints and information about the stage at which complaints were resolved, the time taken to do so, and about the actions that have been or will be taken to improve services as a result of complaints.

3.3. A report to Committee in August 2022 provided information on the agreed Complaints Key Performance Indicators for the Model Complaints Handling Procedures for Local Authorities (LA), which were published in March 2022 on the SPSO website (this includes Health and Social Work Partnerships, in relation to social work functions delegated from LAs). The Committee also received information detailing the 9 NHS performance indicators.

3.4. The NHS Grampian Annual Complaints report provides information on all complaints, concerns, comments and feedback recorded on Datix, this includes any recorded under HSCM. The Annual Complaints Report produced by the Council includes all council related complaints recorded on lagan, this includes any Council related services under HSCM.

3.5. The SPSO have advised to ensure there is no double reporting of figures but it should be made clear where partnerships' complaints performance information is published.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. Given the importance HSCM places on receiving comments and feedback to use to continuously improve services, the experience and satisfaction of people along with their families and carers the Committee agreed, at their meeting on 25 August 2022 (para 6 refers) to continue to publish annual complaints performance information to demonstrate HSCM's commitment to valuing complaints.

4.2. The information from complaints from April 2021 to March 2022 has been collated and presented following the LA KPIs and NHS Performance Indicators. The draft HSCM Annual Complaints Report for 2021/22 is attached at **Appendix 1**.

4.3. The annual report will include links to the Council's and NHSG's Annual Complaints Performance Reports and provides supplementary information specific to Health and Social Care Moray. The draft report can be further refined prior to publication.

4.4. There have been no complaints received relating to the dissatisfaction with the MIJB's policies, decisions or administrative or decision-making processes followed by the MIJB. The MIJB's definition of a complaint is: "*An expression of dissatisfaction by one or more members of the public about the MIJB's action or lack of action, or about the standard of service the MIJB has provided in fulfilling its statutory responsibilities."*

4.5. There was a drop in the number of complaints received during 2020/21, as detailed in the report, which is likely due to the Covid-19 pandemic; in 2020 there were many services that were suspended and many others where service delivery was altered in some way to accommodate the requirements for social distancing.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"

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

Effective handling of complaints is used to ensure the efficient and sustainable delivery of services to meet priorities.

(b) Policy and Legal

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

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

There are systems and processes in place across service areas to support clinical governance, providing assurance to the HSCM Senior Leadership Team and to the Clinical and Care Governance Committee. There are platforms within Health and Social Care to discuss and share good practice, learning and challenges.

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

(e) Staffing Implications

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

(f) Property

None directly arising from this report.

(g) Equalities/Socio Economic Impact

Not required as there are no changes to policy.

(h) Climate Change and Biodiversity Impacts

None directly arising from this report.

(i) Directions

None directly arising from this report.

(j) Consultations

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

- Corporate Manager
- Tracey Sutherland, Committee Services Officer, Moray Council
- Clinical and Care Governance Group

6. CONCLUSION

6.1. The governance and monitoring of complaints forms part of core business for teams and services and provision of a good quality, effective

and safe service is a key priority for all staff. Monitoring and learning from all feedback is an ongoing process.

Author of Report: Isla Whyte, Interim Support Manager
Background Papers: with author
Ref:

Annual Report on

Complaints 2021 – 2022

01/04/21 – 31/03/22

Table of Contents

Introduction

This Complaints Handling Annual Report summaries Health and Social Care Moray's (HSCM) performance in terms of handling complaints during 1 April 2021 and 31 March 2022.

Within HSCM, complaints received by NHS Grampian (NHSG) and Moray Council (the Council) are recorded on 2 separate systems, in accordance with the appropriate policy and procedure of these organisations.

The NHSG Annual Complaints report provides information on all complaints, concerns, comments and feedback recorded on Datix (electronic risk management information system), this includes any recorded under HSCM.

The Annual Complaints Report produced by the Council includes all council related complaints recorded on Lagan (communication management system), this includes any Council related services under HSCM.

Datix is used by NHSG and is therefore accessed by NHS employed staff, Lagan is used by the Council and is used by Council employed staff.

Links to these annual reports can be found here: XXXX

Given the importance HSCM places on receiving comments and feedback to use to continuously improve services the Moray Integration Joint Board (MIJB) have committed to continue to publish annual complaints performance information to demonstrate HSCM's commitment to valuing complaints.

Background

The original Model Complaints Handling Procedures (MCHPs) were first developed by the SPSO in collaboration with complaints handlers and key stakeholders from each sector and were published in 2012. The MCHPs were produced taking account of the Crerar and Sinclair reports that sought to improve the way complaints are handled in the public sector, and within the framework of the SPSO's Guidance on a MCHP.

The MCHPs also reflect the SPSO Statement of Complaint Handling Principles approved by the Scottish Parliament in January 2011. Following recommendations from the Scottish Government's social work complaints working group in 2013, a separate MCHP for social work was developed. The 'Public Services Reform (Social Work Complaints Procedure) (Scotland) Order 2016' (the Order) brought social work complaint handling under the remit of the SPSO Act and subsequently the separate documents for Local Authorities (LA) and Social Work sectors were combined into a single document, the LA MCHP.

The SPSO revised and reissued all the MCHPs (except the NHS) in 2020 under section 16B(5) of the Scottish Public Services Ombudsman Act 2002 on 31 January 2020 to give public sector organisations time to implement any changes by April 2021.

The revised Local Authority MCHP, published 2020, applies to social work complaints, whether they are handled by local authority or health and social care partnership (HSCP) staff.

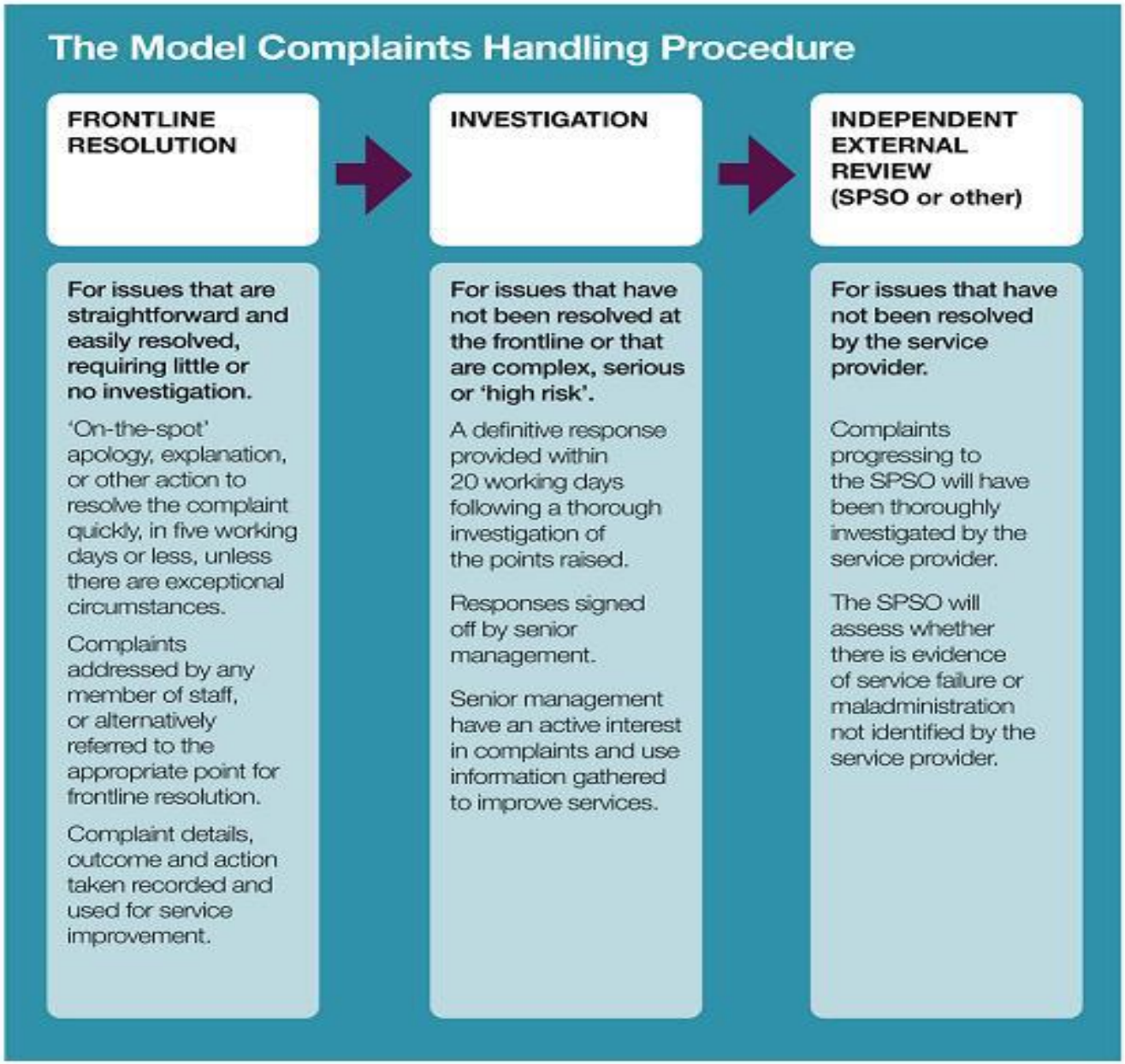
The NHS was the last public sector to adopt the MCHP on 1 April 2017 and it has not yet been revised since it was first published.

Complaints Handling

There is a standard approach to handling complaints across the NHS and Local Authority, which complies with the SPSO's guidance on a model complaints handling procedure and meets all of the requirements of the Patient Rights (Scotland) Act 2011, and accords with the Healthcare Principles introduced by the Act.

The complaints process followed by both NHSG and the Council have the same target response timescales. Early resolution, or front line, complaints will be responded to within 5 working days and complaints handled at the investigation stage have a response time of 20 working days. Where it is not possible to complete the investigation within 20 working days an interim response should be provided with an indication of when the final response should be provided.

The decision as to whether the complaint is upheld or not will be made by the manager or Head of Service. If the person raising the complaint is not satisfied with the outcome then they many contact the Scottish Public Services Ombudsman (SPSO) for an independent review and assessment, however prior to this, every effort is made to engage with the complainant to resolve the matter to their satisfaction.



The governance and monitoring of complaints forms part of core business for teams and services and the provision of a good quality, effective and safe service is a key priority for all.

Key Performance Indicators

Performance Indicators are measures and targets that help assess and demonstrate how functions are carried out.

In March 2022 the agreed Complaints Key Performance Indicators (KPIs) for the Model Complaints Handling Procedures for Local Authorities (LA) were published on the SPSO website. There are four mandatory KPIs for LAs (this includes Health and Social Work Partnerships, in relation to social work functions delegated from LAs). These are:

Indicator One	**The total number of complaints received** *The sum of the number of complaints received at Stage 1 (this includes escalated complaints as they were first received at Stage 1), and the number of complaints received directly at Stage 2.*
Indicator Two	**The number and percentage of complaints at each stage which were closed in full within the set timescales of five and 20 working days** *The number of complaints closed in full at stage 1, stage 2 and after escalation within MCHP timescales as % of all stage 1, stage 2 and escalated complaints responded to in full*
Indicator Three	**The average time in working days for a full response to complaints at each stage** *The average time in working days to respond at stage 1, stage 2 and after escalation*
Indicator Four	**The outcome of complaints at each stage** *The number of complaints upheld, partially upheld, not upheld and resolved at stage 1, stage 2 and after escalation as % of all complaints closed at stage 1, stage 2 and after escalation*

The qualitative indicator on learning from complaints was part of the published draft indicators but has now been removed. However, Part 4 of the SPSO Model Complaints Handling Procedure on Governance stresses the importance of learning from complaints, and the requirements to record and publicise learning.

With regard to Indicator Four the updated MCHP has provided a definition of "resolving" a complaint. "*A complaint is resolved when both the organisation and the customer agree what action (if any) will be taken to provide full and final resolution for the customer, without making a decision about whether the complaint is upheld or not*". This focusses efforts to, wherever possible and appropriate, resolving complaints to the service user's satisfaction. To do this it is necessary to identify and clarify what outcome the service user wants at the start of the process which maybe a change in process for some people currently involved with complaints. It will also change the number of categories of outcomes for complaints to:-

- Upheld
- Not upheld
- Partially upheld and
- Resolved

The above KPIs are applicable for data collected from 1 April 2022.

Complaints about a service that is provided by HSCM on behalf of the NHS, require to be captured using the 9 NHS performance indicators. These are:

- Learning from complaints
- Complaint process experience
- Staff awareness and training
- The total number of complaints received
- Complaints closed at each stage
- Complaints upheld, partially upheld and not upheld
- Average time to close complaints at each stage
- Complaints closed in full within the timescales
- Number of cases where an extension is authorised

The data detailed in this report is based on the four KPIs detailed above and also includes information pertaining to some of 9 NHS performance indicators. For detail on staff awareness and training and the number of cases where an extension is authorised please refer to the NHS Grampian Annual Complaints report.

There is a challenge for reporting of complaints for HSCM due to the fact that there is a need to use two recording systems which then requires collation and as the systems hold data in slightly different ways. This means that there are differences in how the information is reported for some of the indicators.

What is Included

This is HSCM's second published annual complaints performance report. It includes performance statistics, in line with the complaints performance indicators detailed for complaints received about community health and social care services under the direction of the Moray Integration Joint Board.

Any complaints received relating to the dissatisfaction with the MIJB's policies, decisions or administrative or decision-making processes followed by the MIJB will be reported, even if the number is nil. The MIJB's definition of a complaint is: "*An expression of dissatisfaction by one or more members of the public about the MIJB's action or lack of action, or about the standard of service the MIJB has provided in fulfilling its statutory responsibilities.*"

Information about complaints referred to the Ombudsman are also included.

Figures reported do not include complaints raised regarding the vaccination appointments or processes as these are being dealt with through a dedicated team covering the Grampian area.

Summary

Complaints provide valuable information that can be used to continuously improve services, the experiences and satisfaction of people along with their families and carers.

Our Model Complaints Handling Procedure reflects the partnership's commitment to serving the public by valuing complaints.

It seeks to resolve issues through local, early resolution and, where necessary, to conduct thorough, impartial and fair investigations of complaints. This will enable us to address dissatisfaction and should prevent the problems that led to the complaint from occurring again.

Learning from Complaints

Teams and services actively review the outcomes of complaints to see where improvements can be made and learn from the feedback. Complaints provide valuable information which can be used to continuously improve services, the experience and satisfaction of people along with their families and carers.

The tables 1a, 1b, 2 and graph 1 below set out the stages the complaints were closed and what the complaint was about and what action taken.

Table 1a

Complaints Information Extracted from Datix – Actions Taken/Stage (closed complaints)

	Early resolution	Investigation	Ombudsman	Total
Access - Improvements made to service access	1	4	0	5
Action plan(s) created and instigated	0	1	0	1
Communication - Improvements in communication staff-staff or staff-patient	2	21	1	24
Conduct issues addressed	2	1	0	3
Education/training of staff	1	7	0	8
No action required	4	22	2	28
Risk issues identified and passed on	0	1	0	1
System - Changes to systems	0	1	0	1
Share lessons with staff/patient/public	1	6	0	7
Waiting - Review of waiting times	0	2	0	2
Total	11	68	3	80*

**Figure more than total number of closed complaints as there could be multiple actions taken for each complaint*

Table 1b

Complaints Information Extracted from Lagan – reason for complaint (closed complaints)

	Early resolution	Investigation	Total
Complaint against service assessment	3	1	4
Complaint against staff	5	3	8
Other	1	0	1
Process / Procedure	8	0	8
Total	17	4	21

The governance and monitoring of complaints forms part of core business for teams and services and the provision of a good quality, effective and safe service is a key priority for all.

Noted below are some actions arising from the review of complaints received during the last financial year (data extracted from Lagan).

Additional training and support has been made available to teams around communicating with those using services with a focus on having positive and supportive discussions with clients and their families.

Referral processes have been reviewed.

Processes for communicating changes to care packages reviewed.

Consideration and review of processes for recording decisions.

Table 2

Complaints Information Extracted from Datix – Actions Taken by Service (closed complaints)

	Allied Health Professionals	Community Hospital Nursing	Community Nursing	General Ophthalmic Services	GMED	Mental Health - Adult Mental Health	Primary Care Contracts Team	Public Dental Service	Public Health	No value	Total
Access - Improvements made to service access	0	0	0	0	2	2	1	0	0	0	5
Action plan(s) created and instigated	0	0	0	0	0	0	0	0	0	1	1
Communication - Improvements in communication staff-staff or staff-patient	1	1	4	3	12	2	0	0	0	1	24
Conduct issues addressed	0	0	2	0	1	0	0	0	0	0	3
Education/training of staff	0	0	4	0	3	0	0	0	0	1	8
No action required	1	2	4	0	11	8	0	0	1	1	28
Risk issues identified and passed on	0	0	0	0	1	0	0	0	0	0	1
System - Changes to systems	0	0	0	0	0	1	0	0	0	0	1
Share lessons with staff/patient/public	0	0	2	0	3	0	0	1	0	1	7
Waiting - Review of waiting times	0	0	0	0	1	0	1	0	0	0	2
Total	2	3	17	3	34	14	2	1	1	5**	80*

**Figure more than total number of closed complaints as there could be multiple actions taken for each complaint*

***no specific service recorded on datix system*

Active review of complaints through reporting and investigation is a useful tool to identify learning and improve services. Below are some of the actions and learning from complaints closed between 01/04/2021 and 31/03/202 (data extracted from Datix).

Communication	GMED continues to work with stakeholders on patient pathways and professional to professional calls.
	Staff reminded of the importance of sharing information in a timely, appropriate and sensitive manner and acknowledging and responding to correspondence or information received.
	All members of staff have been reminded of the importance of clear and concise communication.
	First point of contact staff reminded that effective communication in a polite and respectful manner is required.
	Staff have been reminded to be mindful of language used when communicating with patients and their families to ensure no misunderstanding of information or intent is taken.
Record Keeping – paper held records and electronic	Learning for staff around dealing with sensitive documentation shared.
	Additional training given regarding contemporaneous paper held record keeping.
	Community Module IT issues escalated to senior management within the appropriate NHSG IT department.
Infection, Prevention and Control	Staff instructed to undertake further Infection, Prevention and Control training including donning and doffing.
System/Process change	A post-operative information sheet to be developed and implemented through the NHSG governance structures to supplement verbal information. This will include post-operative care, guidance and identifying who to contact for further information/support.
Education / training / share lessons learned	Regular Continuing Medical Education (CME) sessions are scheduled for the clinical team to ensure national clinical standards and guidelines are shared and reliably implemented within GMED for a specified condition. These are ongoing and aim to continuously ensure that patients receive evidence-based and consistent care.
	Guidance shared on how to access training programmes. This was especially pertinent to staff who are moving between health board areas.
	Staff were required to undertake additional training and carry out reflective practice. Additional supervision was implemented to support development.
	GMED Service Managers undertook a review of process of investigating complaints, in light of complaint response not meeting timescales.

Care Opinion is a site where anyone can share their experience of health or care services. The following stories relate to HSCM services and were published during this reporting period. For more stories that have been written about NHS Grampian, please visit Care Opinion https://www.careopinion.org.uk/services/sn9

I was an emergency admission to Acute Psychiatric Ward 4. Immediately, on admission, I was calmly re-assured by all Staff on Duty. throughout my recovery, the care I received was second to none.

My initial depressive and anxiety condition was quickly improved with the Professional, Compassionate and Kind treatment I received from every single member of Staff....

From Senior Nurses, Health Care Support Workers....Domestic Staff were also friendly when vital cleaning of each room was carried out !!!!

There is no doubt whatsoever, The entire Team in this ward have GREATLY contributed to my successful return to strong mental health with an added insight to " Behaviour Triggers" to warn me of early signs so no recurrence of this distressing condition, both for myself and my family, who were helped every step of the way on my recovery.

Recently I was not feeling too well around 6pm despite trying to treat myself, but I phoned NHS24 who must have been very busy as it was half an hour before I spoke to a call handler who passed my symptoms to the duty clinician.

The outcome was a 12 mile journey from my home to the Moray GDocs medical clinic at The Oaks Hospice in Elgin. I was seen by the duty Nurse Steven who was very thorough and reassuring throughout my visit for treatment.

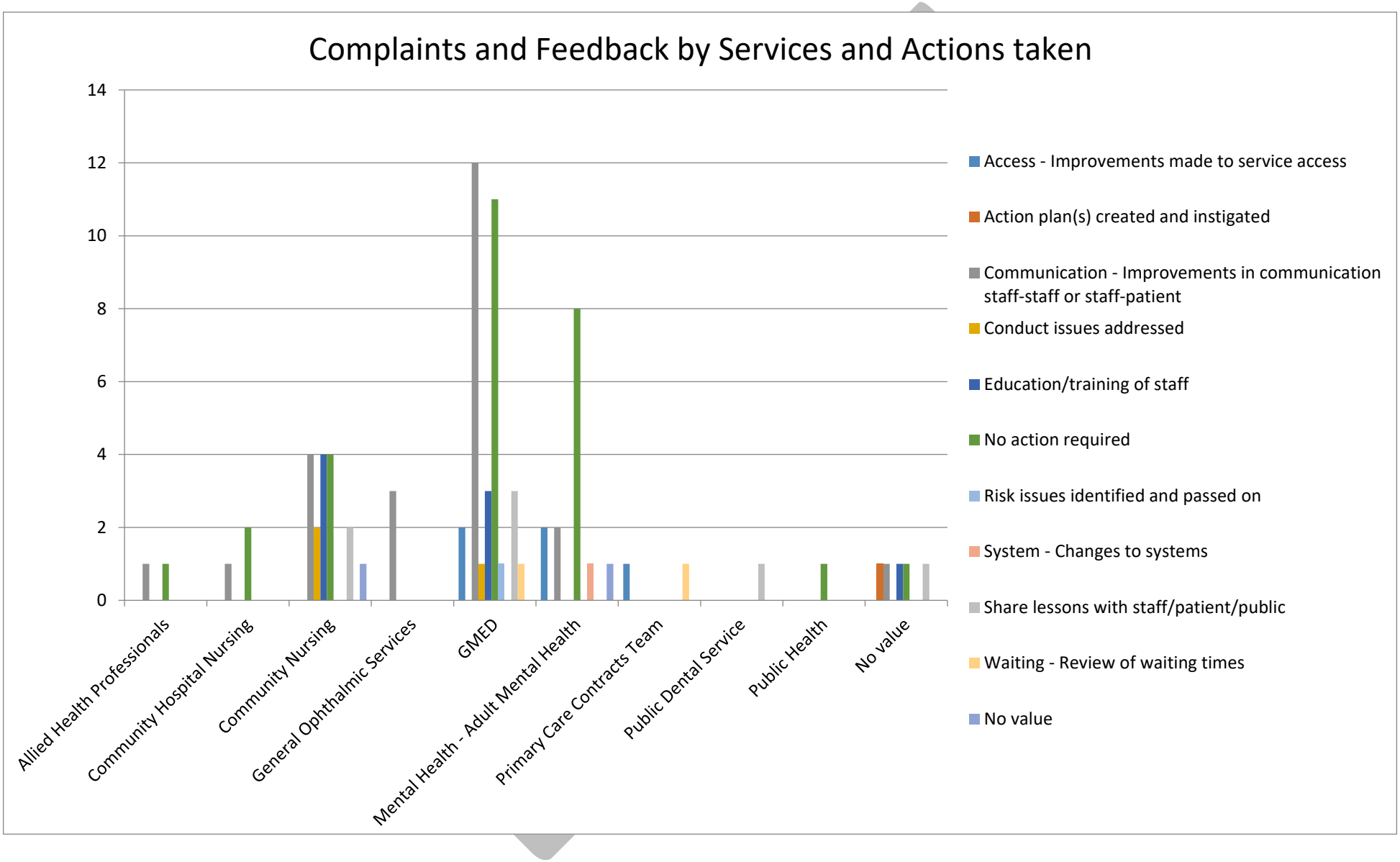
Sincere thanks to all involved as my pain was relieved after being administered an NSAID injection by the empathetic Nurse Steven who also changed my dressings as well as checking out the site where surgery had taken place 10 days prior.

Complaint Process and Experience

NHS Grampian paused the experience survey during the pandemic and recommenced in the second quarter of this year. This survey is sent out to participants 2 months after their complaint was closed. Data is available from complainants whose complaint was closed in March 2022 onwards and will therefore be included in next year's HSCM Annual Complaints Report.

Moray Council issue a customer satisfaction survey to all complainants once their complaint is closed. In 2021/22, Moray Council issued 482 surveys and received 58 responses, giving a return rate of 12%. This is the lowest in recent years with 15% recorded in 2020/21 and 13% in 2019/20. Many of the customer satisfaction surveys are completed as anonymous, unless the customer chooses to insert their complaint reference, there is no way of knowing who the return survey is from or which service it was about. More information on this can be found in the Moray Council Complaints Performance Report.

Graph 1 Complaints Information Extracted from Datix – Action Taken by Service (closed complaints)



Indicator 1 - **The total number of complaints received**

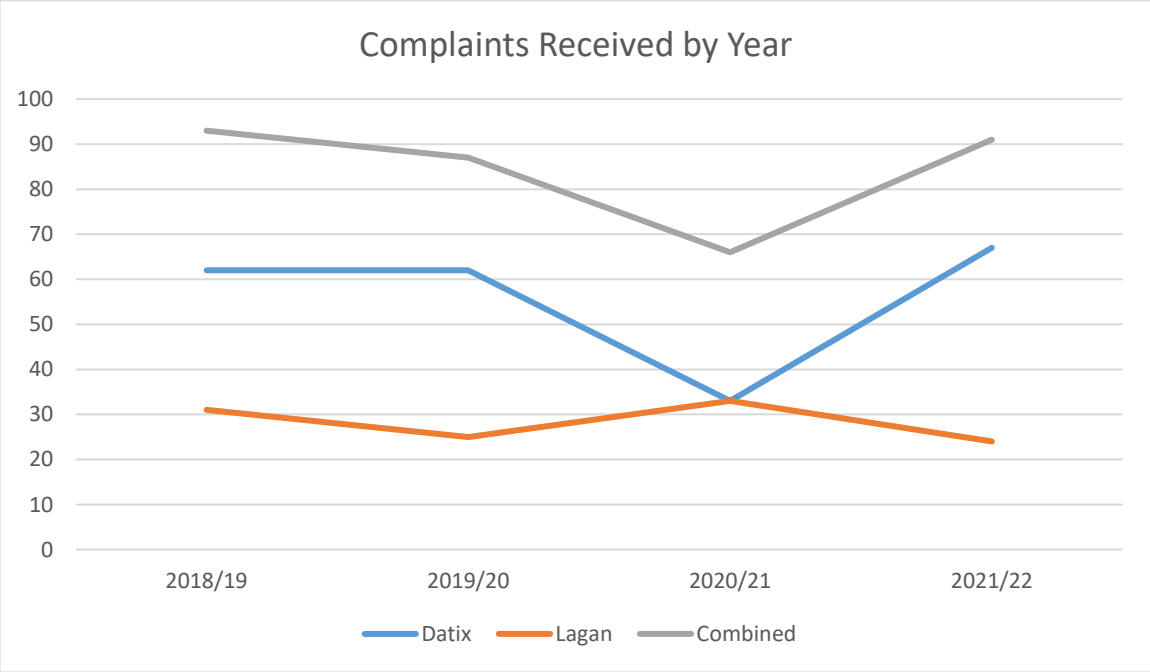
The sum of the number of complaints received at Stage 1 (this includes escalated complaints as they were first received at Stage 1), and the number of complaints received directly at Stage 2.

Table 3 – total number of complaints (received)

System recorded	Early Resolution / Frontline	Investigation	**Total**
NHS - Datix	9	58	67*
Moray Council - Lagan	20	4	24**
Total	29	62	**91**

**Note – 1 complaint received into Datix was closed as no consent was received and 1 complaint was withdrawn – these are not included in Table 4 figures below*
***Note - 2 complaints received into Lagan were cancelled – these are included in Table 4 figures below*

Graph 2 - Complaints Received by Year



Datix – Complaints Received by Year:

Year	Total
2018/19	62
2019/20	62
2020/21	33
2021/22	67

Lagan - Complaints Received by Year:

Year	Total
2018/19	31
2019/20	25
2020/21	33
2021/22	24

There was a drop in the number of complaints NHS received during 2020/21, for health services, which is likely due to the Covid-19 pandemic; in 2020 there were many services that were suspended and many others where service delivery was altered in some way to accommodate the requirements for social distancing.

Table 4 – combined data from Datix and Lagan (complaints received) for 2021/22

	Early resolution	Investigation	Ombudsman	Total
Allied Health Professionals	0	2	0	2
Community Hospital Nursing	1	0	0	1
Community Nursing	2	10	1	13
General Ophthalmic Services	0	3	0	3
GMED	3	22	0	25
Mental Health - Adult Mental Health	2	14	1	17
Primary Care Contracts Team	0	1	0	1
Public Dental Service	1	0	0	1
Public Health	0	2	0	2
Access Team	1	0	0	1
Care at Home	6	2	0	8
Head of Service	4	1	0	5
Learning Disability	2	0	0	2
Mental Health	1	0	0	1
Moray East	1	0	1	2
Moray West	1	0	0	1
Occupational Therapy	4	0	0	4
Total	29	57	3	**89**

Indicator 2 **- The number and percentage of complaints at each stage which were closed in full within the set timescales of five and 20 working days**

*The number of complaints **closed** in full at stage 1, stage 2 and after escalation within MCHP timescales as % of all stage 1, stage 2 and escalated complaints responded to in full*

Table 5 – number and percentage of complaints at each stage closed within timescales

	Early Resolution/Frontline with timescale	Investigation within timescale
NHS - Datix	6 out of 8 (75%)	19 out of 54 (35%)
Moray Council - Lagan	8 out of 17 (47%)	1 out of 4 (25%)

Complaints received into HSCM are often multi-faceted and include more than one service which can impact on response times due to the level of investigation and coordination required.

During last year HSCM were not able to achieve the targets timescales for responding in all cases. This is a particular target area for improvement and work continues to identify obstacles preventing and opportunities to improve response times, raise awareness of the need to seek how to resolve matters to the complainants' satisfaction and to streamline processes.

Indicator 3 **- The average time in working days for a full response to complaints at each stage**

Table 6 – *average time in working days to respond*

	Early Resolution/ Frontline	Investigative
NHS - Datix	5 working days	xx working days
Moray Council - Lagan	14 working days	27 working days

Indicator 4 - **The outcome of complaints at each stage**

The number of complaints upheld, partially upheld, not upheld and resolved at stage 1, stage 2 and after escalation as % of all complaints closed at stage 1, stage 2 and after escalation

Table 7 – Stage 1 – Frontline / Investigative and Escalated (combined data from Lagan and Datix)

Service	Upheld	Partially Upheld	Not Upheld	Grand Total
Care at Home	1	3	2	6
Head of Service	0	3	2	5
Learning Disability	0	2	0	2
Mental Health	0	0	1	1
Moray East	0	1	1	2
Moray West	0	1	0	1
Occupational Therapy	1	1	2	4
Allied Health Professionals	1	0	1	2
Community Hospital Nursing	0	1	2	3
Community Nursing	7	1	2	10
Generic Ophthalmic Services	2	1	0	3
GMED	11	5	10	26
Adult Mental Health	3	2	8	13
Primary Care	1	0	1	2
Primary Care Contracts Team	0	1	0	1
Public Dental Service	1	0	0	1
Public Health	0	0	1	1
Total	28 (34%)	22 (26%)	33 (40%)	**83**

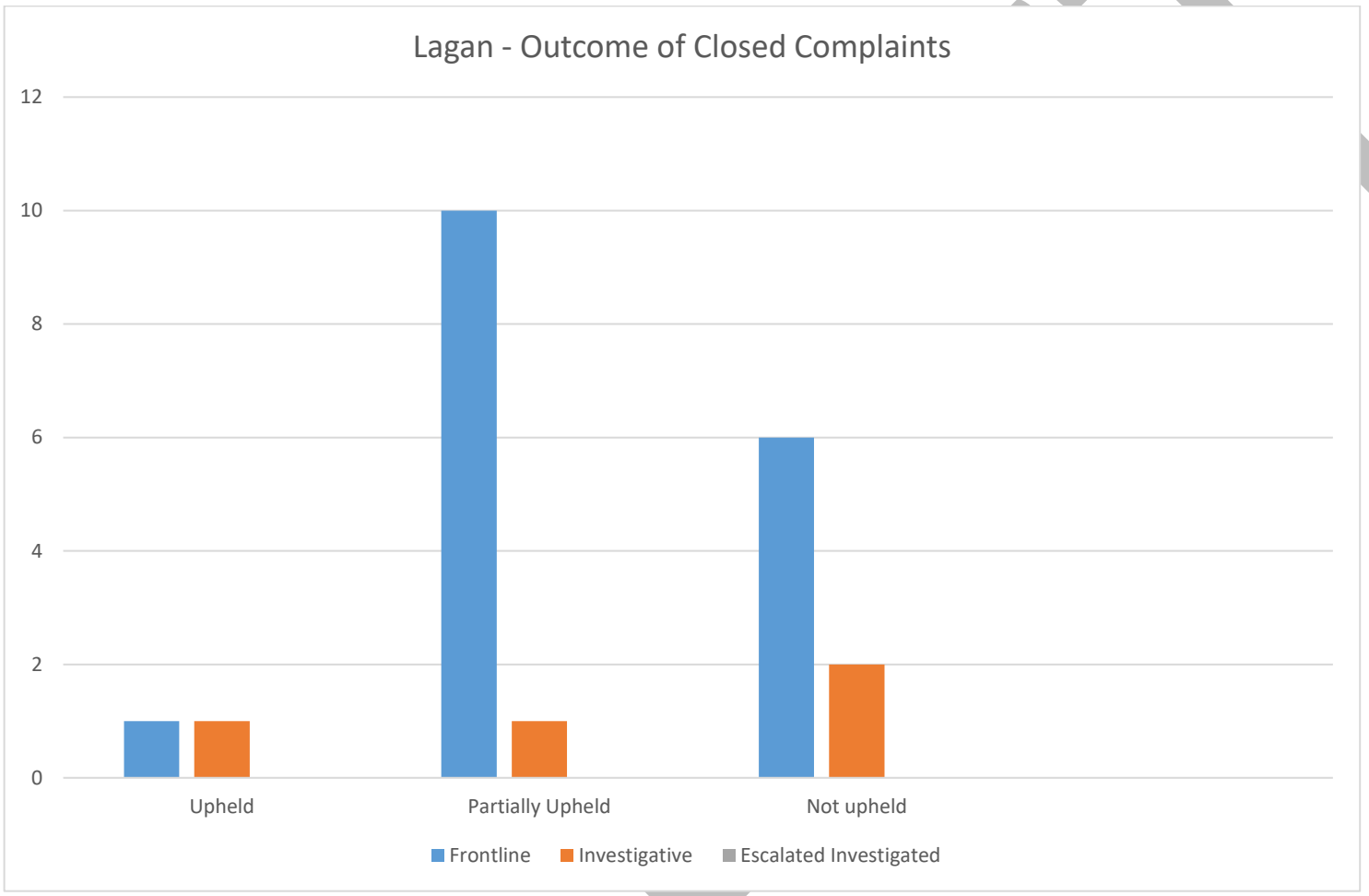
Graph 3 below shows the amount of complaints fully upheld, partially upheld and not upheld as recorded in Datix during 2021/22. Out of 66 closed complaints on the system 2 complaints were withdrawn by complainant, and 2 were closed as consent was not received.

From the remaining 62 complaints closed during 2021/22 **- approximately 42% were fully upheld, 18% were partially upheld and 40% were not upheld**

Complaints Information Extracted from Lagan:

21 complaints were closed during 2021/22: **10% were upheld, 52% were partially upheld and 38% were not upheld**

Graph 4 below shows the amount of complaints upheld, partially upheld and not upheld as recorded in Lagan from the **21 closed** complaints during 2021/22.



REPORT TO: **CLINICAL AND CARE GOVERNANCE COMMITTEE ON 27 OCTOBER 2022**

SUBJECT: **DRUG RELATED DEATHS IN MORAY**

BY: **INTERIM INTEGRATED SERVICE MANAGER**

1. REASON FOR REPORT

1.1. To update the Committee about Drug Related Deaths in Moray 2020, 2021 and into 2022.

2. RECOMMENDATION

2.1. It is recommended that the Clinical and Care Governance Committee consider and note:

i) the Drug Related Death figures for Moray;

ii) the continued work of the service in relation to the Multi-Agency Risk System (MARS) process; and

iii) **the work being undertaken to support the delivery of the Medication Assisted Treatment (MAT) Standards implemented by the Scottish Government in May 2021.**

3. BACKGROUND

3.1 Moray has had a variable trend of Drug Related Deaths. For 2020 these figures have been nationally verified as 10 drug related deaths. Formal verification for 2021 data has yet to take place but numbers of people known to the service were 11. To date in 2022 there have been 5.

3.2 The MARS meetings continue to take place on a regular basis for people known to be high-risk.

3.3 MAT standards are evidence based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland. These are relevant to people and families accessing or in need of services, and health and social care staff responsible for delivery of recovery oriented systems of care.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Drug Related Deaths meetings are chaired and meeting notes held confidentially. The frequency of meetings will be demand led.

4.2 Moray Integrated Substance Misuse Service follow a review process of all the cases open in service for shared learning and debrief.

4.3 Clinical governance will be assured to Moray Clinical and Care Governance Group by completing and submitting the Moray Quality Assurance Reporting Template on a quarterly basis. This includes: reporting of risks; adverse events; learning outcomes from adverse events reviews (drug related deaths); good practice; external reviews of service; peoples' experience of the service – complaints / care experience.

4.4 A local implementation group has been set up to support delivery of MAT standards in Moray. A workshop has recently been held alongside Public Health Scotland colleagues and work is ongoing to ensure implementation of standards within timescales set out for delivery.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019 – 2029"
Moray Drug and Alcohol Partnership Delivery Plan 2021 - 2024 (reviewed and revised November 2021)

(b) Policy and Legal
Improved governance – review and reporting of all drug and alcohol related deaths.

Delivery in line with Rights, Respect and Recovery 2018 – Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths.

(c) Financial implications
There are no financial implications. The Adverse Event Review Process and Multi-Agency Risk System approach are undertaken by existing staff and multi-agency partners.

(d) Risk Implications and Mitigation
As detailed above at Section 4.

(e) Staffing Implications
Additional staff have already been appointed to support delivery of MAT standards, as well as meet increased demand on services. Potential for there to be further implications as further demand is placed on services.

(f) Property
Current accommodation is not fit for purpose, and does not allow service to comply with MAT standards. In addition, colocation with Criminal

Justice Service can be seen as a barrier to people accessing treatment. Work is ongoing to secure alternative premises for the service.

(g) Equalities/Socio Economic Impact
Review of all drug and alcohol related deaths including those people who have died while receiving a service (but may not be a drug or alcohol related death); Participating in Multi-Agency Risk System with partners. Greater surveillance of risks and how to mitigate these. Learning for all partners.

(h) Climate Change and Biodiversity Impacts
None as a direct result of this report.

(i) Directions
None as a direct result of this report.

(j) Consultations

Emma Johnston, Public Protection Lead, Lynsey Murray, Team Manager, Moray Integration Drug and Alcohol Service and Tracey Sutherland, Committee Services Officer, Moray Council. Comments have been incorporated in this report.

6. CONCLUSION

6.1 The approach to reviewing drug and alcohol related deaths and participating in Multi-Agency Risk System will enable Moray to be better placed to learn from drug related deaths; reduce harm to individuals and manage risks for individuals receiving a service. These approaches should reduce Drug Related Deaths in the future.

Author of Report: Teresa Green, Interim Integrated Service Manager, Mental Health and Substance Misuse Service

REPORT TO: **CLINICAL CARE GOVERNANCE COMMITTEE ON 27 OCTOBER 2022**

SUBJECT: **STRATEGIC RISK REGISTER – OCTOBER 2022**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To provide an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated on 17 October 2022.

2. RECOMMENDATION

2.1 It is recommended that the Clinical and Care Governance Committee:

i) consider and note the updated Strategic Risk Register at APPENDIX 1; and

ii) note the Strategic Risk Register will be further refined to align with the transformation and redesign plans as they evolve

3. BACKGROUND

3.1 The strategic risk register is reviewed regularly by the Senior Management Team as part of a robust risk monitoring framework, to identify, assess and prioritise risks related to the delivery of services in relation to delegated functions, particularly any which are likely to affect the delivery of the Strategic Plan.

3.2 The Moray Integration Joint Board (MIJB) Strategic Risk Register is attached to this report at **APPENDIX 1** and sets out the inherent risks being faced by the MIJB, together with a current assessment on the level of the risks and mitigating actions being taken to reduce the impact of the risks. This report is presented to Clinical and Care Governance Committee for their oversight and comment.

3.3 Risk scores are weighted, based on assessment according to their likelihood and corresponding impact, as per Section 5 of the MIJB Risk Policy.

3.4 The Strategic Risks received an initial review to ensure they align to the Moray Partners in Care 2019-2029 strategic plan which was agreed at MIJB on 28 November 2019 (para 13 of the minute refers).

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Risk Management Framework review was completed and outcome was approved by the Board on 25 June 2020 (para 9 of the minute refers). The approved Risk Appetite Statements have been included in **APPENDIX 1**.

4.2 The return to 'business as usual' from the Covid-19 pandemic continues to progress. However, there has not been any relief in the system over the summer period, and is already facing increased staff absences due to seasonal illness and leave.

4.3 Work is being progressed to ensure the Risk Register is updated in the timescales dictated by the criteria. The action has been added as a standing item on the Systems Leadership Group agenda.

4.4 The continued safe delivery of services is a priority and as such, dedicated management time is being directed to support oversight of operational risks. Grampian Operational Pressure Escalation System (GOPES) continues to be utilised to assist in the identification of pressure points across the whole system so that they can be addressed and prioritised appropriately. A review of these principals was revisited during a workshop across the Moray Portfolio on 17 October 2022. This highlighted the ongoing pressures facing the entire system and allowed for worthy discussions about how best to capture those pressures.

4.5 The ability to cope with unforeseen incidents continues to provide challenges to the systems. The national cyber-attack on NSS Scotland systems debrief is planned to conclude in November 2022. It is intimated that improved practices across the system have been captured as part of their ongoing planning and recovery phase. These will be captured and shared to Senior Management Team and MIJB in due course.

4.6 The possibility of planned power outages raised by SSEN. Civil contingency groups are discussing options and reviewing Business Continuity Plans to ensure planning is underway. Discussions between Scottish Government and Senior Management are also taking place around Protected Sites.

4.7 Ballots are proceeding for the possibility of Staff Industrial Action. The outcomes of these ballots is expected in November 2022. Planning meetings are already underway to address the possible outcomes and actions.

4.8 There continues to be significant financial risk in the system. Future reports will incorporate updates to the MIJB.

4.9 Recruitment and selection to staff vacancies continues to prove challenging across most services. Staff wellbeing continues to be a key priority and a significant emphasis is being placed on ensuring that everyone is provided with the support that is readily available, where it is required. The issues that have been identified and factored into the developing workforce plan. This

ongoing work will be progressed with partners across Grampian for recruitment.

4.10 The new Care at Home contract, with Allied working in partnership with the Council's internal provision, started in October 2021. This contract limited Self-Directed Support (SDS) option 3 supply to Allied and internal provision. Prior to the new Care at Home contract HSCM also contracted with the other providers under SDS option 3. This ended, after a short extension, in April 2022. The providers were then only contracted to supply care under SDS options 1 and 2.

There are currently a significant number of hours per week of unmet need for care at home, with little change in these figures this year. There is an urgent need to increase supply to support the health and social care system.

The Moray Portfolio Additional Flow Huddle has agreed to explore the potential for expanding the Care at Home SDS option 3 provision with a view to increasing the supply of Care at Home. Moray Council procurement support using the existing Scotland Excel national Care at Home framework for other external care at home providers. The plan is to provide a 12 month contract for these other providers to support capacity and create a wider group of support over the next few months. This workplan has been brought to the attention of the Chair and Vice Chair of the MIJB to try and address the unmet need identified.

4.11 With the confirmation of the NHSG Portfolio arrangements across Grampian and the likely delegation of Children and Families and Criminal Justice services to MIJB, there will be a need for alignment of the governance frameworks and a transition phase to accomplish this effectively. It is anticipated that this work may be presented to the MIJB in spring 2023.

4.12 As plans evolve, the Strategic Risk Register will continue to be updated to ensure that it reflects any potential risks to realise the vision set out in our Strategic Plan.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2019-2029"

The MIJB requires effective governance arrangements for those services and functions delegated to it and Risk Management systems are integral to this.

(b) Policy and Legal

As set out in the terms of reference, the Board has responsibility to provide assurance of the adequacy of the risk management framework.

There are no legal implications arising from this report.

(c) Financial implications

There are no direct financial implications arising from this report however the Board should note the failure to manage risks effectively could have a financial impact for the MIJB.

(d) Risk Implications and Mitigation
This report forms part of the governance arrangements for identifying and managing strategic risks of the MIJB. The risks are outlined in the body of the report in section 4.

(e) Staffing Implications
There are no additional staffing implications arising from this report.

(f) Property
There are no property implications arising from this report.

(g) Equalities/Socio Economic Impact
An Equalities Impact Assessment is not required because there are no service, policy or organisational changes being proposed.

(h) Climate Change and Biodiversity Impacts
There are no impacts arising from this report.

(i) Directions
None arising from this report.

(j) Consultations
Consultation has taken place with Sean Coady, Head of Service

6. CONCLUSION

6.1 This report and appendix contains proposed risk appetite statements that, when approved, will underpin the MIJB approach to strategic decision making.

6.2 The report outlines the current position and recommends the Board note the revised and updated version of the Strategic Risk Register.

Author of Report: Sonya Duncan, Corporate Manager
Background Papers: held by HSCM
Ref:

Appendix 1

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT 17 OCTOBER 2022

RISK SUMMARY

1. The Moray Integration Joint Board (MIJB) does not function as set out within the Integration Scheme, Strategic Plan and in-line with Standing Orders and fails to deliver its objectives or expected outcomes.
2. There is a risk of MIJB financial failure in that the demand for services outstripping available financial resources. Financial pressures being experienced by the funding Partners will directly impact on decision making and prioritisation of MIJB.
3. Inability to recruit and retain qualified and experienced staff to provide safe care whilst ensuring staff are fully able to manage changes resulting from integration.
4. Inability to demonstrate effective governance and effective communication and engagement with stakeholders.
5. Inability to cope with unforeseen external emergencies or incidents as a result of inadequate emergency and resilience planning.
6. Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.
7. Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance falls below acceptable level.
8. Inability to progress with delivery of Strategic Objectives and Transformation projects as a result of inability to resolve data sharing and data security requirements.
9. Requirements for support services are not prioritised by NHS Grampian and Moray Council.

RISK RATING	LOW	MEDIUM	HIGH	VERY HIGH
RISK MOVEMENT	DECREASE	NO CHANGE	INCREASE	

The process for managing risk is documented out with the MIJB Risk Policy.

1		
Description of Risk: *Regulatory*	The Integration Joint Board (IJB) does not function as set out within the Integration Scheme, Strategic Plan and Scheme of Administration and fails to deliver its objectives or expected outcomes.	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**MEDIUM**
Risk Movement:	Increase/ decrease/ no change	**INCREASING** ↑
Rationale for Risk Rating:	The strategic plan "Partners in Care" 2019 to 2029 was developed and launched in December 2019. Membership of IJB committees has recently changed due to the elections in May. An amendment to the Scheme to increase membership by one from each of the partner organisations was ratified in March 2022 by the Scottish Government following due process and approval by Moray Council and NHS Grampian Board. During the initial Covid 19 response, normal business was suspended and emergency arrangements were implemented. IJB, CCG and APR meetings restarted during August 2020. Weekly meetings were instigated with Chair/Vice Chair and Chief Officer and these continue. Progress is underway to review the Strategic Plan "Partners in Care" 2019 to 2029 which will be completed by December 2022.	
Rationale for Risk Appetite:	The Board, staff and providers across Moray are all committed to ensuring high standards of clinical care & governance through operational policies. Innovation and new ways of working may mean traditional regulations do not exist, or are contradictory. We will only take regulatory risks knowingly, following consultation with the relevant regulatory body and where we have clear risk mitigation in place.	
Controls:	• Integration Scheme. • Strategic Plan ""Partners in Care" 2019 to 2029 • Governance arrangements formally documented and approved by MIJB January 2021. • Agreed risk appetite statement. • Performance reporting mechanisms. • Consultation with legal representative for all reports to committees and attendance at committee for key reports. • Standing orders have been reissued to all members	
Mitigating Actions:	Induction sessions were held for new IJB members after May elections. . IJB member briefings are held regularly as development sessions. Conduct and Standards training held for IJB Members in June 2022 provided by Legal Services .	

	SMT regular meetings and directing managers and teams to focus on priorities. Regular development sessions held with IJB and System Leadership Group Strategic Plan and locality management structure is in place The work that has been progressed through the Covid19 response has escalated developments in some areas as a matter of priority. This has been achieved through collaborative working with partner organisations and the third sector.
Assurances:	• Audit, Performance and Risk Committee oversight and scrutiny. • Internal Audit function and Reporting • Reporting to Board.
Gaps in assurance:	The Covid 19 Response caused a delay in producing the Transformation Plans which in turn has impacted on communication and engagement with staff and partners in respect of the intended outcomes. Work is underway on the refresh of the Strategic plan and will incorporate the work being taken forward for Self-Directed support, Three conversations, Locality Planning, Hospital at home and Hospital without walls. A delivery plan will be developed alongside the refreshed Strategic Plan.
Current performance:	Scheme of administration is reported when any changes are required. Legal advisors are currently working on the requirements to the integration scheme in relation to the proposed delegation of Children's and Families and Justice Services. Report presenting the Strategic Plan, Communication Strategy, Organisational Development and Workforce Plans, Performance Framework and the draft Transformational Plan were presented and approved at MIJB on 28 November 2019 Governance Framework was approved by IJB 28 January 2021.Re-appointment of Standards Officer agreed by IJB 31 March 2022 Members Handbook has been updated and circulated to all members in June 2022.
Comments:	Strategic Planning and Commissioning Group approved the generic Terms of Reference and Chairs of the transformation boards at the meeting on 19 December 2019. It was intended that these boards would be established by April 2020 however this work was on hold due to Covid19 and is now restarted but will incorporate the changes on new ways of working and will recommend a revised way forward. The interim Strategy and Planning Lead is now taking this forward and prioritising and focusing on strategic planning and priorities over the short and longer term.

2		
Description of Risk: *Financial*	There is a risk of MIJB financial failure in that the demand for services outstrips available financial resources. Financial pressures being experienced both by the funding Partners and Community Planning Partners will directly impact on decision making and prioritisation of MIJB.	
Lead:	Chief Officer/Chief Financial Officer	
Risk Rating:	Low/ medium/ high/ very high	**VERY HIGH**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	Whilst the 2020/21 and 2021/22 settlement saw additional investment for health and social care that was passed through to the MIJB, there remains a significant pressure due to the recurring core overspend, since most of the new investment related to new commitments. Financial settlements are set to continue on a one year only basis, which does not support sound financial planning. In addition, many uncertainties have arisen through the Covid response and continue as we continue to remobilise. The full impact is not yet quantifiable. The Revenue Budget 2022/23 was approved by MIJB on 31 March 2022 as a balanced budget. A small savings plan of £0.11 million was approved. Additional Scottish Government investment is provided again for 2022/23, this is to meet additional policy commitments in respect of adult social care pay uplift for externally provided services and seeks to ensure that capacity can be maximised and ensuring system flow. The final outturn position will be finalised and reported to the MIJB in June where it is anticipated there will be a small general reserve. The update medium Term Financial Framework was presented as part of the budget papers on the 31st March 2022 however, it is imperative that this is further reviewed during the 2022/23 year to ensure alignment with the upcoming revisions to the Strategic Plan.	
Rationale for Risk Appetite:	The Board recognises the financial constraints all partners are working within. While we are cautious and open about accepting financial risks this will be done: • Where a clear business case or rationale exists for exposing ourselves to the financial risk • Where we can protect the long term sustainability of health & social care in Moray The Covid-19 recovery continues to place additional risk on the MIJB finances as we continue through the pandemic, recover and transform. Whilst we are now officially in the recovery phase there has been no change in the pressures felt by the system during the summer period.	
Controls:	There is an interim arrangement for CFO cover from Moray Council. Permanent recruitment efforts have not been successful. The Chief Officer is working with both the Council and NHS Finance Leads to secure a longer term interim arrangement.	

	The CFO and Senior Management Team have worked together to address further savings which will be presented to the Board for approval as part of the budget setting procedures for 2022/23. This should be a focus of continuous review to ensure any investment is made taking cognisance of existing budget pressures. A revised Financial Framework was presented to the MIJB on 31 March 2022, and a further review will take place once the current strategic plan has been reviewed to assure alignment.
Mitigating Actions:	Risk remains of the challenge that the MIJB can deliver transformation and efficiencies at the pace required whilst dealing with the pressures that are emerging as a result of the pandemic. Financial information is reported regularly to both the MIJB, Senior Management Team and System Leadership Group. The Chief Officer and Chief Financial Officer (CFO) continue to engage in finance discussions with key personnel of both NHS Grampian and Moray Council. These conversations have continued throughout the pandemic phase. Chief Officer and CFO will continue to engage with the partner organisations in respect of the financial position throughout the year. Cross partnership performance meetings are in with partner CEOs, Finance Directors and the Chair/Vice Chair of the MIJB.
Assurances:	MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.
Gaps in assurance:	None known
Current performance:	An overspend of £692,246 was reported to the IJB at 30 June 2022. The Scottish Government have announced their intention to reclaim surplus Covid reserves, the details of this are as yet not confirmed.
Comments:	Senior managers continue to work with Chief Officer and Chief Financial Officer to address the continuing financial challenge, continuing to seek efficiencies and opportunities for real transformation as we look to make efficient and effective investment in services that are truly transformational. There are additional pressures from the cost of living crisis, increasing energy bills, inflation and the potential for staff industrial action.

3		
Description of Risk: *Human Resources (People):*	Inability to recruit and retain qualified and experienced staff to provide and maintain sustainable, safe care, whilst ensuring staff are fully able to manage change resulting from response to external factors such as the impact of Covid and the actions that arose from the recommendations from the Independent Review of Adult Social Care 2021.	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**HIGH**
Risk Movement:	Increase/ decrease/ no change	**INCREASING**
Rationale for Risk Rating:	There continues to be issues with recruitment to some front line services that require specific skills and experience. This has been the case for some time now and continues to place pressure on existing staff. Allied Health Professions, Social Work are two particular areas experiencing difficulties with obtaining people with the appropriate skills and training. Care at Home staffing levels are pressured for Internal services and externally with local providers all experiencing the same difficulties. There are also impacts on recruitment of Dentists and other graduates arising from Covid as the number graduating has reduced during the period. The various impacts of Covid-19 has placed a significant strain on the Partnerships resources across frontline and support functions and this has resulted in delays for the progress of projects relating to the achievement of strategic objectives. The Care Homes in Moray have continued to do well to maintain their staffing levels throughout the pandemic however there are examples where there is a reliance on agency staffing. The difficulty with recruitment and retention of staff to care at home roles in particular is still being experienced. Efforts are being made to provide support but the situation remains challenging. The transition from EU membership has not presented any specific concerns for workforce and this will continue to be monitored. The impact of budgetary decisions by the Council in relation to reducing staffing levels has reduced levels of support provided in some key areas for Health and Social Care Moray (HSCM), such as ICT, HR, Legal and design.	
Rationale for Risk Appetite:	Safety risks that could result in harm to service users, staff or the public are inherent in Health & Social Care services. The safety of individuals is paramount therefore standards of safety management and clinical care have to be high, and the Board will continue to seek assurances this is the case. The Board's ambition is for health & social care to be people centred. This means supporting people in decision making about their own health & care, which may expose individuals to higher risk where they make an informed decision. The Board will also seek to balance individual safety risks with collective safety risks to the community.	
Controls:	Management structure in place with updates reported to the MIJB.	

	Organisational Development plan in place and Workforce Plans are being updated to align to the new strategic plan. Continued activity to address specific recruitment and retention issues. The chief social worker reviewed the situation with managers and employed a Consultant Practitioner to develop options for addressing some of the particular issues affecting social work services in Moray and to provide support to managers and staff Management competencies continue to be developed through Kings Fund training although this was suspended due to Covid19. Communications & Engagement Strategy was approved in November 2019 and is being implemented. Council and NHS performance systems in operation with HSCM reporting being further developed and information relating to vacancies, turnover and staff absences is integral to this. Managers are highlighting any areas of concern and where appropriate this is identified in operational risk registers. HSCM services have commenced weekly reporting of workforce sit reps for Senior Management Team oversight highlighting vacancies, annual leave, sickness absence and Covid impacts so that issues can be identified and assessed quickly.
Mitigating Actions:	System re-design and transformation. Organisational Development Plan and Workforce plan were updated and approved by MIJB in November 2019. The updated Workforce plan has been submitted to Scottish Government and comments were received by the HSCP in October 2022. These are currently being worked through. These plans are core documents for the Workforce Forum which has recently re-commenced following a temporary suspension during the first quarter of this year due to Covid impact. Staff Wellbeing is a key focus and there are many initiatives being made available to all staff including training, support, information and access to activities. Locality Managers are developing the Multi-disciplinary teams in their areas and some project officer support has been provided to develop the locality planning model across Moray. Lead Managers are involved in regional and national initiatives to ensure all learning is adopted to improve this position. Lead Managers and Professional Leads are linked to University Planning for intakes and programmes for future workforce development.
Assurances:	Operational oversight by Moray Workforce Forum has resumed and will report to MIJB in accordance with the agreed Governance framework. The HSCM Response Group was in place over the whole period of the Covid19 pandemic providing focussed leadership around emerging issues and resolving them. This group stood up again in April and is meeting daily whilst

	the system is pressured, this will be reviewed as the situation evolves. The Heads of Service are co-ordinating and escalate to SMT where necessary. These meetings have been increased as service needs dictate.
Gaps in assurance:	Further work required to develop workforce plans to reflect strategic plan implementation programmes once they are agreed.
Current performance:	The IMatter survey results for 2021 were received by managers for review and action plans. Preparatory work is commencing on the action plans for IMatter 2022 Discussions are underway with HR in both Council and NHS to develop access to appropriate HR information at a summarised level to facilitate the necessary workforce planning and subsequent monitoring of plans. There continues to be a need for more streamlining in recruitment processes as the delay in approval to recruit to having a member of staff available is in excess of 8 weeks. There is also a lack of suitable applicants for various posts which is impacting on ability to appoint for some roles.
Comments:	Staffing issues are owned by the Systems Leadership Group who will work collaboratively across the system to seek opportunities to make jobs more attractive where it has proved difficult to recruit in the past. For some professions there is a potential risk that staff move from one position to a new position within HSCM will just move the vacancy to elsewhere in the system, so Senior Management Team are aware of this risk and taking it into account in considerations for vacancies. There is a concern that if the continuing system issues and beds continue to be blocked for new patients it will mean operations cannot be scheduled to reduce the backlog and key staff may not have the necessary time in surgery to maintain skills. This in turn may add to the staff retention issues within certain specialties.

4		
Description of Risk: *Reputation:*	Inability to demonstrate effective governance and effective communication and engagement with stakeholders.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Locality planning assessed as medium in relation to ability to work at the pace required and current workforce capacity. Performance framework to be further developed from a planning perspective to show the links through operational service delivery to strategic objectives. Recent engagement with individuals representing their communities or third sector organisations in a variety of forums is highlighting that problems with their capacity to fulfil our needs so more co-ordination and clearer focus is required to ensure that the communication, engagement and outcomes are meeting identified needs.	
Rationale for Risk Appetite:	The Board is cautious but open about risks that could damage relationships with different stakeholders. It recognises many of our aspirations depend on effective collaboration, coproduction and partnership working with a range of stakeholders. The appetite also recognises that while the aspiration is to be a co-operative partner, some partners will not be able to move at the same pace as us all the time. We will seek to protect relationships in the long term and will not set out to antagonise stakeholders deliberately. For example, we must not be seen to exclude or prevent participation in the design of services where there is an appetite to do this. We must be mindful that repairing relationships is easier when there is already a well of goodwill to draw on, and that further damage to an already damaged relationship will not be conducive to good long term outcomes.	
Controls:	Governance Framework approved by IJB January 2021 Communication and Engagement Strategy approved November 2019 Annual Governance statement produced as part of the Annual Accounts 2019/20 and submitted to External Audit. Annual Performance Report for 2020/21 was published in August 2021 Performance reporting mechanisms in place and being further developed through performance support team, home first group and system leadership team. Community engagement in place for key projects areas such as Forres, Keith and Lossiemouth with information being made available to stakeholders and the wider public via HSCM website.	

	Participation of stakeholders in a variety of meetings such as Home First project, carer strategy, Strategic, Planning and Commissioning groups.
Mitigating Actions:	Schedule of Committee meetings and development days in place and implemented. Good working relationship established with Audit Scotland, the MIJB's appointed external auditors since 16/17. Discussions at leadership meetings to ensure all standards are being met around Public Sector Equality Duty and published where appropriate. There is a new programme of training to ensure all policies are Impact Assessed and the findings are published. Annual Performance Report for 2021/22 will be published in November 2022 after being presented to the IJB. Social media is actively used as a method of engaging with the public, with short videos focussing on particular services being trialled. SMT have considered the existing arrangements for engagement with stakeholders and work is being undertaken to align our framework with the Scottish Government "Planning with people guidance" and ensure that mechanisms are in place across services to evidence and evaluate their impact.
Assurances:	Oversight and scrutiny by Clinical and Care Governance Committee, Audit Performance and Risk Committee and MIJB. Summary reports of minutes of MIJB meetings are submitted to Council committee and NHS Board.
Gaps in assurance:	Progress on implementation of the Communication and Engagement Strategy has been impacted by the Covid 19. Due to the impact of COVID and requirement for social distancing the normal mechanism for engagement were not all available. More use is being made of social media and Microsoft teams and other options and methods for engagement with staff are being used via NHSG such as videos on YouTube and one question surveys. Going forward there may be more opportunity for face to face meetings to take place again but it should be considered that this will not be beneficial for all.
Current performance:	Communications Strategy was reviewed approved by IJB November 2019. Annual Performance Report 2020/21 published August 2021. Audited Accounts for 2020/21 were publicised by deadline 30 September 2021 Due to Covid19 there have been increased levels of briefings to staff, the public and Chair/Vice Chair of MIJB with a focus on the key elements of the response. The staff newsletter commenced during Covid continues to be distributed.
Comments:	A communication cell was established as part of the Local Resilience Partnership Covid and storms response with representation from Councils, HSCP and NHSG. This was led by Aberdeen City Council and was an example of the collaborative working that took place. This forum provides assurance that messages to all stakeholders are consistent.

	It also ensures that there is support for our Communications Officer and resilience provided with the access to other communication officers. There has been representation from the Home first project at the Wellbeing forum to facilitate sharing of information and seeking views.

5		
Description of Risk: *Environmental:*	Inability to cope with unforeseen external emergencies or incidents as a result of inadequate emergency and resilience planning.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Due to the response requirements for Covid 19 progress has been made in a number of areas. SMOC information is updated, control room guidance updated and expanded, control centre protocols were implemented and remain in place and management teams have responded in an agile, responsive and collaborative way under very challenging conditions. Teams continue to do their best but there are areas where they still feeling overwhelmed and service delivery is challenging. With effect from March 2021 MIJB is defined as a Category 1 responder under the Civil Contingencies (Scotland) Act and there are additional requirements for preparedness that is being taken forward in partnership with NHSG and Moray Council emergency planners.	
Rationale for Risk Appetite:	The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act and the Category 1 status applied in March 2021, and work with partner organisations to meet these obligations	
Controls:	Winter Preparedness Plan was updated (but not tested as in previous years) alongside NHSG plans as NHSG implemented their crisis management framework which required participation of partners at Daily connect meetings to discuss and prioritise resource to address issues with system flow. HSCM Civil Contingencies group established and meeting regularly to address priority subjects. NHS Grampian Resilience Standards Action Plan approved (3 year). Business Continuity Plans in place for most services although overdue a review in some areas. Knowledge of critical functions and ability to respond quickly and effectively has been in evidence during incidents such as Gas outages in Keith (January and February 2021) and Covid response, Storms (Arwen, Malik and Corrie) – debriefs carried out and learning identified. Debriefs being undertaken for HSCM, Moray (Council and HSCM) and Local Resilience Response with lessons learnt being collated and prioritised for an action plan.	
Mitigating Actions:	Information from the updated BIA/BCP informed elements of the Winter Preparedness Plan A Friday huddle is in place which gathers the status of services across the whole system to provide information and contact details to the Senior Manager on Call (SMOC) over the weekend.	

	NHSG have introduced system wide daily huddles to manage the flow and allocation of resources which require attendance from Dr Grays and HSCM. Practitioner group established for Moray with representation from HSCM, Dr Grays, Moray Council and NHSG to discuss matters arising from the Local Resilience Forum and within our respective organisations. In addition it will provide a forum for discussion of the linkages between organisational response plans to ensure there are no gaps or over reliance on particular local resources. HSCM continues to monitor the local situation regarding impacts on staffing and is engaged with NHSG emergency planning arrangements and Council Response and Recovery management team to be ready to escalate response if required. Work was undertaken within NHSG, Aberdeenshire HSCP and Aberdeen City HSCP to look at Surge flows and establish a mechanism that will provide easy identification of "hot spots" across the whole system in Grampian, to facilitate a collaborative approach to addressing the issues through the use of a common Operational Pressure Escalation approach. This work could underpin surge responses in winter and at other times of pressure and having a standard approach across Grampian could aid communication and understanding.
Assurances:	Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny. HSCM Civil Contingencies group review specific risks and action plans to mitigate, developing plans and testing arrangements in partnership with NHSG and Council
Gaps in assurance:	Moray Integrated Joint Board (MIJB) was designated as a Catagory 1 responder under the Civil Contingencies Act 2004 from March 18th 2021. That designation imposed a number of statutory duties in terms of the Act and the associated Scottish Regulations[1]. MIJB has no dedicated, specialist in post and is reliant on the corporate manager covering this increasingly demanding role in addition to other duties without the necessary background, knowledge, skills and experience. This presents a potential organisational risk in terms of compliance and our ability to provide assurance on discharging our civil contingency arrangements. The debriefs from the storms in 2021/22 have identified lessons learnt for Grampian Local Resilience Partnership and more locally for the response co-ordination within Moray. Action plans are being developed in collaboration with Moray Council's emergency planning officer to address the issues identified. The main issues related to developing wider awareness of roles and responsibilities, and improving general awareness of response structures and meeting protocols. This will be incorporated into training schedules going forward. It has also highlighted the need for a robust arrangement for out of hours contact and clarity of roles and responsibilities across the system which is being discussed at SMT. Option Appraisal discussions are intended to commence end October 2022.

[1] Civil Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005

	Progress has been made however further work is required to address the targets in the implementation plan that have not been met and the Resilience standards as identified by the NHSG Civil Contingencies Group. Due on ongoing system pressures and staff vacancies the Care for People plan and associated response structures has not been completed to date. It is anticipated this will be completed by end October 2022, allowing for the operational response plans to be drawn up. The intention is to hold a table top exercise with managers from HSCM and Moray Council to test the invocation arrangements to ensure common understanding of roles and responsibilities.
Current performance:	The Senior Management Team participated in Strategic Leadership in a Crisis training in 2020 and a programme of further training for the wider management team is scheduled. Many services have business continuity arrangements and some are overdue for an update. Work has progressed in identification of a critical functions list for agreement by System Leadership Group that will inform planning arrangements going forward. There will need to be changes made to business continuity plans following the implementation of additional ICT resources in services which have provided a greater deal of resilience for some services and functions – albeit reliant on electricity supply. A schedule of review and exercising of business impact assessments and plans has been scheduled for this year across services. Annual report on progress against NHS resilience standards was reviewed by APR committee on 31 March 2022. Report on the implications of the designation as a Category 1 responder was presented to MIJB 25 November 2021. Information has been collated regarding dependencies of fuel for delivery of critical functions for submission to NHSG and Council for inclusion in the planned response to the invocation of the National Fuel Plan. Work is currently underway to plan for possible National Power Outages across the UK. This is being co-ordianated across Grampian to ensure all Partners are involved.
Comments:	The requirements of a Category 1 Responder continue to increase in demand placing increased pressures across already overstretched services and managers. MIJB does not have a subject matter expert leading on these topics.

6		
Description of Risk: *Regulatory*	Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**INCREASING** ↑
Rationale for Risk Rating:	Considered medium risk due to the impact of Covid-19 and resultant efforts required to remobilise services and/or the increase in workloads stretching a workforce that has been under sustained pressure for a considerable time. The ongoing impact of the Covid 19 pandemic is stretching resources to deliver care in the community across all providers (internal and external) so there is a potential increased risk of expected standards not being achieved despite the best efforts of all concerned.	
Rationale for Risk Appetite:	The Board, staff and providers across Moray are all committed to ensuring high standards of clinical care & governance through operational policies. Innovation and new ways of working may mean traditional regulations do not exist and require to be developed, no longer apply, or are contradictory. We will only take regulatory risks knowingly, following consultation with the relevant regulatory body and where we have clear risk mitigation in place.	
Controls:	Clinical and Care Governance (CCG) Committee established and future reporting requirements identified Clinical Risk Management and Practice Governance group has oversight of their respective professional standards and feed into Clinical and Care Governance Group, which then escalates to CCG Committee as necessary. High and Very High operational risks are reviewed by System Leadership Group monthly and a review of all risks will be undertaken as part of the risk management framework. Complaints and compliments procedures in place and monitored. A complaints co-ordinator role is being developed and will be implemented to reduce duplication of effort, to provide co-ordination and improve information flow and support managers in responses with the intention of streamlining processes and improving achievement of target timescales. Clinical incidents and risks are being reviewed on a weekly basis to ensure processes are followed appropriately and consistently and responses are recorded in a timely manner. Adverse events and duty of candour procedures in place and being actioned where appropriate and summary reports submitted to CCG committee.	

	Reports from external inspections reported to appropriate operational groups and by exception to SMT for subsequent reporting to CCG or Audit Performance and Risk Committee as appropriate, albeit there has been a reduction in some areas of external inspection reporting during the Covid period due to social distancing restrictions Care Home Oversight Group meets to oversee and manage risks in care homes. Children and Adult Protection services are being delivered and reported to their respective committee on a regular basis.
Mitigating Actions:	This risk is discussed regularly by the three North East Chief Officers. Additional resource has been allocated to support the analysis of information for presentation to CCG committee All High and Very High risks are now brought before the senior management team in Moray. Process for sign off and monitoring actions arising from Internal and External audits has been agreed
Assurances:	Audit, Performance and Risk and Clinical and Care Governance Sub-Committees oversight and scrutiny. Governance Framework in place and operational.
Gaps in assurance:	Process for highlighting recurring themes or strategic expectations from external inspections requires further development to ensure Committee has sight of significant issues. The vacancy of clinical governance co-ordinator has now been appointed to and this will be part of their work programme.
Current performance:	External inspection reports are reviewed and actions arising are allocated to officers for taking forward. A summary of inspections is included in the Annual Performance report. The level is marked as an increasing risk on the basis that services are under pressure with the issues with staffing capacity and the need to focus on delivery of critical functions which may mean external inspection are not the priority at this moment in time. The Adult Support Protection inspection took place in April/May and our action plan has been developed.
Comments:	No major concerns have been identified for HSCM services in any audits or inspections during 2021/22.

7		
Description of Risk: *Operational Continuity and Performance:*	Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance of services falls below acceptable level.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Potential impacts to the wide range of services in NHS Grampian and Moray Council commissioned by the MIJB arising from reductions in available staff resources as budgetary constraints impact. Unplanned admissions or delayed discharges place additional cost and capacity burdens on the service. The level of delayed discharges has remained high, reflecting the sustained pressure in the system following the Covid -19 pandemic impact and the lack of availability of care in the community. There are sustained focussed and collective efforts by all those working in the pathway. However this is a complex area and will require continued effort to realise reductions and maintain them.	
Rationale for Risk Appetite:	The Board is cautious but open about risks that could affect outcomes that are priorities for people in Moray. There is a slightly higher appetite to risks that may mean nationally set outcomes – that by design are not given a high priority in Moray - are not met. This will only be accepted where there is a clear rationale, and preferably also a way of demonstrating what the IJB is doing to meet the aspiration the outcome was created for.	
Controls:	Performance Management reporting framework. 2019 to 2029 “Partners in Care” Strategic Plan approved and refresh of Plan and development of implementation plans underway. Performance regularly reported to MIJB. Revised Scorecard being developed to align to the new strategic priorities. Best practice elements from each body brought together to mitigate risks to MIJB’s objectives and outcomes. Chief Officer and SMT managing workload pressures as part of budget process. A daily Huddle and write up circulates the picture on performance across community and acute services for the Portfolio and service managers have a shared understanding of the pressures in the system and mitigations taking	

	place. Work continues on refinement of G-OPES (Grampian Operating Pressures and Escalation System) led by NHSG but being developed locally to identify the triggers and resultant actions required in services to respond to pressure points.
Mitigating Actions:	Service managers monitor performance regularly with their teams and escalate any issues to the System Leadership Group (SLG) for further discussion to provide wider support, developing shared ownership and a greater understanding across the whole system. Key operational performance data is collated and circulated daily to all managers. A Daily dashboard is held on illuminate for managers to access to ensure any potential issues are identified quickly so action can be taken. This dashboard is being reviewed and will be further developed with the intention of further dashboards to provide a whole system overview. This has been discussed at SLG and agreed. Performance information is presented to the Performance sub group of Practice Governance Group to inform Social Care managers of the trends in service demands so that resources can be allocated appropriately.
Assurances:	Audit, Performance and Risk Committee oversight. Operationally managed by service managers, summary reports to Practice Governance and clinical and care governance group and to System Leadership Group. Strategic direction provided by Senior Management Team. HSCM Response Group continues to meet and reviews the key performance information and actions that are required to deliver the priority services.
Gaps in assurance:	Development work in performance to establish clear links to describe the changes proposed by actions identified in the Strategic Plan has recommenced but is at an early stage. This will be progressed as the revised outcomes are determined and associated KPI are identified. Progress will be reported to future Board meetings.
Current performance:	The Covid19 pandemic impacted on all areas of the service and work is underway to take the learning and experience gained during the response to collate performance information in dashboards to support mangers interpret the impact of Covid19 on their services, now and going forward. There are likely to be changes to ways of working and this may also have impact on the performance information required.
Comments:	Locality profile information has been provided to Locality Steering Group/Locality Manager to inform potential priorities for consideration in Localities and work will be taken forward regarding development of performance monitoring and reporting of key performance indicators in relation to Localities once it has been determined what the intended outcomes are. The delayed discharge group has produced an action plan for implementation and progress is being made.

	Practice Governance have reviewed their operational performance requirements and have a comprehensive data set used to inform operational priorities. The Home First priorities are being taken forward and updates are reported to this committee or MIJB on a regular basis. Progress in this area has been hampered due to the increased demand for urgent or critical services requiring staff resource to be prioritised to frontline service delivery. The Council has procured new modules for their performance reporting system Pentana and HSCM performance team has been developing its its use for reporting.

8		
Description of Risk: *Transformation*	Inability to progress with delivery of Strategic Objectives and Transformation projects.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	There are many issues that will impact on the ability to progress to deliver Strategic Objectives. The Strategic Planning & Commissioning group has been refreshed and re-launched and key work is being progressed. There was an initial meeting held on 22 September 2021 to consider terms of reference and the proposed structure for oversight, prioritisation and assurance in relation to key developments, their fit with IJB strategy and enabling elements. The interim appointment of the Strategic and Planning Lead provides capacity to take this forward and to align the priorities arising nationally, Grampian-wide and locally. The remobilisation plan for HSCM services that were suspended or reduced is progressing with Providers services and social work implementing the IJB decision to return to delivery of both substantial and critical eligibility criteria. Work has progressed risk assessments are completed and assessments have been or are in the process of being reviewed to ensure equality. The impact of Covid 19 on the population of Moray is still not fully realised. It is therefore not possible to predict the extent of the impact on the ability to progress with delivery of Strategic Objectives. There are some aspects that have progressed very well such as introduction of Near Me consultations but there are others that are more difficult to progress.	

	There is concern that due to the workloads and challenges over the last year that teams are weary and/or do not have capacity at this moment in time, to progress with delivery of development plans at this moment in time. In addition the pandemic is still present in the community so services are still responding to the impacts it has for the population of Moray. Managers are working with teams to establish "readiness" and their capacity and sense of wellbeing and the collated output will inform plans going forward. One key aspect to facilitate transformation is the need for progress in relation to ICT infrastructure, data sharing and data security across the whole system. Work was undertaken by NHS GRAMPIAN and partners to address the needs for ICT kit and information during the response to Covid.
Rationale for Risk Appetite:	The Board has a high appetite for risks associated with delivery of transformational redesign. The following should be considered when accepting these risks: • We understand and can mitigate other risk types that may arise, e.g. safety or financial within appetite • Service users are consulted and informed of changes in an open & transparent way • We will monitor the outcome and change course if necessary
Controls:	It is recognised that there will be significant changes taking place in Social Work practice with the implementation of the Self Directed Support standards and the move to outcomes based services, so governance arrangements are being set up to facilitate the same type of oversight and communication that is in place for the Home First programme.
Mitigating Actions:	Integrated Infrastructure Group previously established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters which is an area that will be taken forward alongside the Moray Growth Deal projects. Linkages to Infrastructure board and Information sharing groups have been established albeit these meetings are not taking place regularly at the moment.
Assurances:	Strict ICT and data sharing policies and protocols in place with NHS Grampian and Moray Council.
Gaps in assurance:	Transformation/implementation planning is in development and will inform outcomes and performance reporting on the delivery of the strategic plan. Protocol for access to systems by employees of partner bodies are in place. Information Management arrangements to be developed and endorsed by MIJB. Process of identification of issue and submission to data sharing group requires to be reinforced to ensure matters are progressed.

	Smarter Working programmes are being progressed in partnership with Council and NHSG.
Current performance:	Training programme to be developed on records management, data protection and related issues for staff working across and between partners.
Comments:	Where national systems are involved it may not be possible to identify a solution however the issues will be able to be raised at the appropriate level via the Grampian Data Sharing Group where all three partnerships are represented.

9		
Description of Risk: *Infrastructure*	Requirements for support services are not prioritised by NHS Grampian and Moray Council.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Changes to processes and necessary stakeholder buy-in still bedding in. Moray Council is undertaking a Property review of office and depot accommodation and the potential impact for HSCM services requires consideration. The output was anticipated in October 2019 however due to changes with roles and responsibilities within the Council however the paper has been out for consultation. NHSG have advised that staff should continue to work from home at present whilst policies and protocols are developed. Moray Council have a dedicated MC officer leading on a hybrid working plan with input from HSCM on their requirements. ICT infrastructure service plans in NHS Grampian and Moray Council are not yet visible to HSCM and development of communication and engagement process is required. The impact of Covid has resulted in a change in ICT strategy for Moray Council. Council employed staff requiring mobile technology have now been provided with it and some staff are still working from home.	
Rationale for Risk Appetite:	Low tolerance in relation to not meeting requirements.	
Controls:	Chief Officer has regular meetings with partners Computer Use Policies and HR policies in place for NHS and Moray Council and staff. PSN accreditation secured by Moray Council Infrastructure Programme Board was established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT. Process for submission of projects to the infrastructure board approved and implemented to ensure appropriate oversight of all projects underway in HSCM. The Board is not meeting at present, so in the interim, project requests are being processed via Senior Management Team. The interim Strategy and Planning Lead will support the the Infrastructure Programme Board for Moray portfoilio to be re established.	

Mitigating Actions:	Membership of the Board was reviewed and revised to ensure representation of all existing infrastructure processes and funding opportunities. Process for ensuring infrastructure change/investment requests developed Dr Gray's strategy (vision for the future) is being produced collaboratively with input from NHSG and HSCM management.
Assurances:	Infrastructure Programme Board functions to provide robust governance and assurance that proposed projects have a robust business case and meets requirements of the respective partner organisations. This board reports to Strategic Planning and Commissioning Group. Both of these groups are being refreshed and remobilised. Workforce Forum meeting regularly with representation of HR and unions from both partner organisations
Gaps in assurance:	Further work is required on developing the process for approval for projects so that they are progressed timeously. Need to review all existing processes in relation to infrastructure changes/projects/investments and streamline to avoid duplication of effort. Infrastructure Board is in development and priority issues are being addressed in relation to infrastructure and premises risk. Legal services have reduced capacity to provide support due to budget cuts and vacancies so any requests may take longer. Recruitment for vacancies takes considerable time due to various factors and is presenting a strain on services to maintain normal service whilst covering vacancies. There have been several posts that have had to go out to advert more than once extending the time other staff are covering gaps.
Current performance:	No update.
Comments:	Existing projects will be reviewed as part of the development of the transformation plans for the Strategic Plan to ensure resources are being dedicated appropriately and aligned to the emerging Strategic priorities. Our requirements for support will be communicated via appropriate channels