Clinical and Care Governance Committee

Thursday, 26 August 2021

To be held remotely in various locations

NOTICE IS HEREBY GIVEN that a Meeting of the **Clinical and Care Governance Committee** is to be held at **To be held remotely in various locations**, on **Thursday, 26 August 2021** at **09:30** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

MEMBERSHIP

Professor Nicholas Fluck (Chair)

Councillor Frank Brown (Vice-Chair)
Jane Ewen (Member)

Mr Ivan Augustus (Non-Voting Member)
Ms Karen Donaldson (Non-Voting Member)
Ms Jane Mackie (Non-Voting Member)
Dr Malcolm Metcalfe (Non-Voting Member)
Mrs Val Thatcher (Non-Voting Member)
Dr Ann Hodges (Non-Voting Member)

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

MINUTE OF MEETING OF THE MORAY INTEGRATION JOINT BOARD

CLINICAL AND CARE GOVERNANCE COMMITTEE

Thursday, 27 May 2021

remote locations via video conference

PRESENT

Prof Nick Fluck, Cllr Frank Brown, Mr Ivan Augustus, Mr Simon Bokor-Ingram, Mrs Jane Mackie and Mrs Jeanette Netherwood.

APOLOGIES

Dr Malcolm Metcalfe, Samantha Thomas and Mr Sean Coady

IN ATTENDANCE

Also in attendance at the above meeting was Alex Pirrie, CAMHS Manager – Grampian; Carmen Gillies, Senior Project Officer – HSCM; Zandra Smith, Adult Support & Protection Lead, Pam Cremin, Integrated Service Manager – MH and SM Services; Kandarp Joshi, Consultant – Adolescent Psychiatry; and Mrs Isla Whyte, Interim Support Manager, as clerk to the Board.

1. Chair of Meeting

The meeting was chaired by Prof Nick Fluck.

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' Interest in respect of any item on the agenda.

4. Minute of Meeting of Clinical and Care Governance Committee on 25 February 2021

The Minute of the meeting dated 25 February 2021 was submitted for approval.

The Board agreed to approve the minute as submitted.

5. Action Log of Clinical and Care Governance Group on 25 February 2021

The Action Log of the meeting dated 25 February 2021 was discussed and updated accordingly at the meeting.

6. Clinical and Care Governance Group Escalation Report for Quarter 4, 2020/21

A report by Sean Coady, Head of Service, informs the Committee of progress and exceptions reported to the Clinical and Care Governance Group during quarter 4 of 2020/21 (1 January up to 31 March 2021).

In Mr Coady's absence Mrs Mackie informed the Committee that the Clinical and Care Governance Group is now much further established since the inclusion of social care representatives. The group now receive regular service updates following an agreed reporting schedule.

Mrs Netherwood advised, CRM continue to meet every fortnight to review risks, adverse events and complaints and input where necessary. CRM recently heard in more detail about the monthly educational sessions held for the Grampian Medical Emergency Department (GMED) to learn from adverse events. This learning can be shared with the Committee if they wish.

Mr Augustus seeks reassurance that HSCM is continuing to improve ways of reporting. He would like to see evidence that the partnership are reporting in accordance with Scottish Public Services Ombudsman (SPSO) Complaints Standards Authority and it is fit for purpose. Mr Augustus would like to see learning from complaints and evidence of its effectiveness in future reports and if there have been any complaints made against the IJB.

Mrs Netherwood recognises the need to improve reporting and ensure information from the NHS system and the Council system is presented in a consistent way.

Mrs Mackie noted the Council complaints system has changed in accordance with SPSO's updated Model Complaints Handling Procedures and 'first line' complaints that weren't being logged prior to April 2021 will now be.

Following further discussion the Committee agreed to receive a report specifically around complaints to the next meeting of the Clinical and Care Governance Committee in August 2021. The report should set out:

1. Statutory obligations and confirmation they are being met
2. Themes emerging from complaints
3. Approach to learning from complaints and actions being delivered

Information about complaints referred to the ombudsman to also be included along with any complaints made against the IJB.

In response to a question from Councillor Brown, the Chair advised that 'No value' on the table detailing adverse events by category could mean either no action is

required as negligible event or that a level had not yet been allocated at the time of reporting.

The Chair noted a large number of adverse events reported fall into two categories:

- Abusive, violent, disruptive or self-harming behaviour
- Accident (including falls)

The Chair advised he would be interested to understand the distribution of the those events under the first category i.e. harm to patients or harm to staff/ care givers, the themes and action taken to address. Mrs Cremin advised a large number of these events can be attributed to a small number of very challenging patients both in adult and older adult mental health inpatient areas and in particular one patient. Mrs Cremin went on to advise that staff are encouraged and supported to report all adverse events; all incidents are taken seriously and reporting enables appropriate surveillance. The Moray Mental Health team have sought support and advice from colleagues in Aberdeen to help manage this patient. Support systems are in place for staff and debriefs are conducted where required.

The Committee noted the contents of the report and requested a report specifically on complaints to the Committee in August, detailing the three domains discussed, across both NHS and Council systems.

7. Adult Support and Protection Improvement Plan

A report by the Chief Social Work Officer informs the Committee of the Adult Support and Protection (ASP) improvement journey.

Mrs Mackie introduced the item stating adult support and protection is a multi-agency responsibility. A joint inspection of adult protection activity will be undertaken in 2021 or early 2022. This will be a joint inspection of all statutory partners (police, health and local authority) conducted by the relevant three regulators (Care Inspectorate, HIS and HMIC).

During 2019, preparations began for the anticipated Care Inspectorate ASP thematic inspection. A self-evaluation exercise was undertaken and a multi-agency Improvement Action Plan was developed. A delay occurred in implementing the improvement plan due to the global pandemic. It has been agreed to focus on phase 1 of the plan – policy, process and procedures. It is anticipated that phase 1 will be finished by the end of this year. Phase 1 also covers NHS Grampian requirements to produce and facilitate a pan Grampian approach for Initial Referral Discussions (IRDs). There are strong links with colleagues across Grampian to support this.

It is recognised there is lots of work to do to be fully compliant or congruent with the scrutiny bodies, this is reflected in the improvement plan.

The Care Inspectorate have produced a new set of quality indicators and framework. A further self-evaluation locally will be undertaken to ensure still fit for purpose.

It was noted there is a complex governance structure around adult, support and protection.

Additional resources are funded until March 2022. It was noted therefore this interim mitigation is not sustainable and this is reflected on the risk register.

The committee noted the continued work on the delivery of the ASP Improvement Plan in anticipation of a Care Inspectorate ASP inspection.

8. Mental Health Officer Service in Moray

A report by the Chief Social Work Officer informs the committee of the current situation in the Mental Health Officer Service in Moray.

The Committee discussed the actions agreed by the MHO Governance Group. It was noted Aberdeenshire and Highland are in a similar situation. The sheer geographical distance involved in the Highland area means there is no MHO cover for the rural locations out of hours.

Efforts to reduce the waiting list for guardianship reports include MHOs working additional hours. Mrs Mackie advised the team have also recruited some small additional input.

The Committee noted the current situation within the Mental Health Officer service in Moray and the actions being taken by the MHO Governance Group to mitigate.

9. Out of Hours Mental Health Service Provision for 16-18 Year Olds

A report by the Service Manager, Child and Adolescent Mental Health Services, informs the Committee of the current gap in out of hours mental health service provision for young people aged 16-18 years in Moray and actions that are being taken to address this.

Ms Pirrie advised there was a quick turnaround required for this paper and apologised for a couple of errors in the report. First page the report should read Service Manager, Child and Adolescent (not adult) Mental Health Services. At 4.1 it should read under 18 years not 16 years.

The report was written to highlight the lack of access out of hours for a mental health assessment for 16 and 17 years olds in Moray. There are a number of issues to be addressed including change in staff profile and the way in which services are being delivered. A short life working group has been convened with key stakeholders from across the system in Moray to address this gap.

There are nurse practitioners willing to undertake mental health assessments for these young people, with the right consultant support. Some Consultant Psychiatrists in Moray are not child mental health specialists. It was noted 16-17 age group have a much higher incident rate of presenting out of hours seeking help than under 16s. This presents a high risk for the organisation if a young person attends Dr Gray's Hospital following overdoes or with suicidality and are unable to get a mental health assessment.

It is clear the CAMHS in Grampian is for people aged 0-18 years.

This risk is being recorded on the CAMHS risk register and Moray's local risk register.

The Chair noted the need for a longer term plan and an immediate short term solution. Colleagues are to explore options of support from Grampian Health Board for Junior Doctors and Nurse Practitioners in Elgin for times when there isn't local Consultant Psychiatrist support available.

The Committee noted the contents of this initial report and agreed to receive a fuller report with update on progress made at the next meeting on 26 August 2021.

It was agreed to add a third recommendation:

III. Inform the Committee, within the next week, of immediate risk mitigation plan to gain support from colleagues across Grampian and clarify that in risk register entry.

10. Home First in Moray – Pathway Assurance

A report by Sean Coady, Head of Service, provides the Committee with assurance in relation to the pathway for a patient under the remit of Discharge to Assess.

This paper was formulated in a response to a request from the Committee for an assurance around the pathway in terms of quality and safety.

The programme began operating as a 6 month pilot from October 2020 to March 2021 and a full report was submitted to MIJB on 25 March 2021 when the MIJB approved permanent funding

Since then an Occupational Therapists and Physiotherapist have been recruited and will be in post by end of June 2021. Six Support Workers have been interviewed and an advanced nurse practitioner post is to be advertised next then admin support recruited once clinical team in place. Induction process and intensive training will be undertaken for all new staff members.

The Committee are assured the same checks and measures are in place for patients following the Discharge to Assess pathway; they must meet the criteria and consent to the pathway. It is clear that these patients and clinically or medically stable for early supported discharge.

Ms Duncan advised that, to her knowledge, no complaints have been received or adverse events recorded to indicate any patient has been compromised as a result of following the Discharge to Assess pathway.

It is not anticipated this will have any impact on care in terms of expectations on family etc as if a need for ongoing care is identified then there are mechanisms in place to make those referrals in a timely way. Recognise the connection but this process is around rehab and functional goals. D2A focuses on the patient journey and aims to prevent people becoming deconditioned or adversely affected by a longer than necessary hospital stay. Mr Bokor-Ingram advised the Committee that since the end of the pilot programme delayed discharges have increased.

In response to a question around value for money, Mr Bokor-Ingram stated that once the team is fully operational discussions around efficacy can take place. It is noted the team are not funded beyond this financial year. Future discussions around investment / disinvestment and value for money to be determined by MIJB.

The Committee notes the example pathway described in the report and notes further reports will be submitted to the Committee in relation to developments in pathways arising from the Home First project.

11. Confidential Item – MWC Authority to Discharge

A report by the Chief Social Work Officer informs the Committee of the Mental Welfare Commission (MWC) Authority to Discharge Report which was released on 21 May 2021 and the outcome for Moray.

The report contains personal information, which requires to be discussed in private in order to uphold the principles of the Data Protection Act 2018.

The Committee noted the content of the report and its appendices.

Items for Escalation to MIJB

From discussions at today's Committee, members agreed the following items which create a significant Clinical and Care Governance risk, should be escalated to the MIJB.

- Adult Support and Protection Improvement Plan – identified areas of practice to be improved
- High Risk around Out of Hours Mental Health Assessment for 16/17 year olds – at time of escalation hope to have immediate risk mitigation in place
- Pressures in Mental Health Officer service,

The meeting closed at 11:30

MEETING OF MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE

THURSDAY 27 MAY 2021
ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Review of Clinical and Care Governance – Output from Workshop	Further progress update will be provided to Clinical and Care Governance Committee in August 2021.	August 2021	Jeanette Netherwood
2.	Mental Health in Moray	Paper explaining the risks and contingencies in place in relation to Mental Health Officers and out of hours service – briefing was issued to members on 11.01.21. An update report will be presented in May to CCG Cttee. Update on Mental Health will be presented to March MIJB.	May 2021 - **complete**	Jane Mackie
3.	Health and Social Care Moray Complaints	Further development of complaints performance information to be progressed in liaison with Council Complaints Officer.	May 2021 **Combined with item 4**	Pauline Merchant
4.	Clinical and Care Governance Escalation report for Quarter 4	Complaints report to be presented to CCG Committee – covering: 1. Statutory obligations and confirmation if they are being met 2. Themes emerging from complaints 3. Approach to learning from complaints and actions being delivered	August 2021	Jeanette Netherwood

5.	Out of Hours Mental Health Service Provision for 16-18 year olds	Immediate mitigation plan for OOHs mental health services provision for 16-18 years to be shared with Committee and confirmation this risk is recorded on relevant risk registers with risk mitigation detailed. Update from SLWG on progress made	3 June 2021 August 2021	Alex Pirrie Alex Pirrie and colleagues
6.	Additional item	Add Items for Escalation to MIJB to agendas going forward	August 2021	Committee Services
7.	Items for Escalation to MIJB	The following items to be escalated to MIJB	June 2021	Chair of CCG Committee

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 26 AUGUST 2021**

SUBJECT: **HEALTH & SOCIAL CARE MORAY (HSCM) CLINICAL AND CARE GOVERNANCE GROUP ESCALATION REPORT FOR QUARTER 1 (APRIL TO JUNE 2021)**

BY: **JANE MACKIE, HEAD OF SERVICE/CSWO**
SAM THOMAS, 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 1 of 2020/21 (1 April up to 30 June).

2. RECOMMENDATION

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

3. BACKGROUND

3.1. The Health and Social Care Moray (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 3.2 of the minute refers).

3.3. As reported to the Committee on 29 October 2020 (para 5 of the minute refers) Social Care representatives now attend the Clinical Governance Group. As such the group was renamed HSCM Clinical and Care Governance Group. With Ms Samantha Thomas, Chief Nurse - Moray, and Mrs Jane Mackie, Head of Service / CSWO, as co-chairs.

3.4. The agenda for the Clinical and Care Governance Group has been updated and now 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 in place (as described in a report to this committee on 27 May 2021, para 6 of the minute refers). 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 required. Since April 2020, the 3 minute brief template has been used for services to share their updates; this has been met with positive feedback.

3.5. The Clinical and Care Governance Group have met 3 times 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 1 2021/22 is listed below:

- ASP Self- Assessment Return
- Policy & Procedure following a Death in Care Services
- Adverse Events Policy
- Risk Control Notices
  - maintaining Water Safety
  - Water Sources and Potential Infection Risk to Patients in High Risk Areas
  Summary of External Inspection to NHS Scotland Boards
- Significant Case Review
- Medication Management Policy & Procedures
- Duty of Candour Annual Report
- Healthcare Improvement Scotland (HIS), Combined Care of Older People/Safety & Cleanliness and Covid-19 focused Inspection: ARI, NHS Grampian; Royal Infirmary of Edinburgh; University Hospital Crosshouse, NHS Ayrshire & Arran.
- Mental Welfare Commission: Udston Hospital, NHS Lanarkshire; Royal Edinburgh Hospital.
- Risk Register.
- Adverse Events.
- Feedback and Complaints.

Areas of achievement / Good Practice

4.2 Community Optometry shared learning sessions have remobilised, providing a platform to share good practice and learning.

4.3 The Quality and Patient Safety Committee at Seafield Hospital is proving to be a popular forum and a successful platform for shared learning. While still in its infancy, it is planned that as the forum evolves, it will provide an opportunity for joint training events with colleagues from all disciplines.

The core group currently meet 6 weekly and comprises of GP's, Consultant Geriatrician, AHP's, Social Work, Nursing Staff and management associated with the hospital. The standing agenda focusses on all governance aspects including Older People in Acute Hospital inspection programme (OPAH) standard compliance and audit, complaints and risk, DATIX and significant event analysis. The group are keen to put together an improvement programme and have made links with Quality Improvement (QI) leads to take forward local improvement priorities, adopting QI methodology to implement and share best practice.

4.4 The specialist Community Learning Disability Nursing Team (CLDT) identified that their client group would be largely unable to attend the mass vaccination centre to receive their Covid vaccinations. In collaboration with the management team at the Fiona Elcock Vaccination Centre (FEVC), they undertook vaccination training, including anaphylaxis and Basic Life Support to support the safe and effective delivery of vaccinations to a high risk cohort of people within Moray. The commitment and solution focused approach of the CLDT has ensured that this vulnerable client group have received vaccination, offering protection against COVID 19, which may otherwise have been impossible to attain to the extent achieved. 80% of vaccinations were carried out by the CLDT, 15 % attended the centre and 5% declined.

4.5 Mental health services have moved to a mixed model of care delivery with increasing use of Near Me virtual appointments as well as telephone consultations. Although some patients will continue to be seen face to face within a clinic setting, the number of these is far fewer than before. Feedback from patients is that they prefer having options for being seen. A patient feedback survey is currently being developed for completion at the end of a Near Me consultation and this will allow the service to make any improvements if issues are identified. The use of technology also offers patients more flexibility e.g. saves travelling time and prevents them having to take time off work to attend appointments. The service is about to commence its first virtual group with a 12 week Mentalizaton Based Therapy group running from 9 August and planning for further online groups is underway.

4.6 Pharmacotherapy Service - all practices now have Pharmacists and Technicians in situ. Completion of interviews will complete provision of level 1 within the spec and allow teams to take on more work from GP's. The absorption of Elgin Community Surgery (ECS) into Maryhill has been challenging but has been achieved with help from other practices. The busiest days Monday and Friday are well-staffed to manage the increased work load and any unplanned issues prior to and after a weekend. An advert has been circulated to recruit a GP on a sessional basis to provide support within pharmacotherapy and medication.

Clinical Risk Management (CRM)

4.7 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.

4.8 The group is attended by members of the senior management team, clinical leads, chief nurse and relevant service managers / consultants. 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.

Complaints and Feedback

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

4.10 A report to the Committee meeting on 29 October 2020 (para 7 of the minute refers) provided members with detail on the procedures for NHS and Local Authority complaint handling to demonstrate the similarities and differences.

4.11 Overall, a total of **19** complaints were closed during quarter 1.

	Total Received in quarter 3	**Total Received in quarter 4**	**Total Received in quarter 1**
Local Authority	9	6	9
NHS	9	9	14
Total	18	15	23

	Total Closed in quarter 3	**Total Closed in quarter 4**	**Total Closed in quarter 1**
Local Authority	6	9	4
NHS	9	5	15
Total	15	14	19

4.12 Please see **Appendix 1** for details of complaints closed during quarter 1 of 2021/22 (1 April to 30 June).

4.13 These figures 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.

4.14 Complaints received into Datix 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.

Adverse Events

4.15 An adverse event is defined as an event that could have caused (near miss), or did result in, harm to people of groups of people.

4.16 Please see **Appendix 2** for details of adverse events recorded during quarter 1 of 2021/22 (1 April to 30 June).

4.17 In quarter 4 there were 108 Level 3 reviews under abusive, violent, disruptive or self-harming behaviour. For quarter 1 this has reduced to 68 for the same category. Further analysis shows the increase in events in quarter 4 was

attributed to a small number of very challenging patients both in adult and older adult mental health inpatient areas.

Findings and Lessons Learned from incidents, complaints and reviews

4.18 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.

4.19 There is currently one Level 1 review in progress (at the time of reporting).

4.20 **Findings** from the Level 1 review completed in the last quarter concluded that delays in access to face to face assessment due to rapid deployment of new working practices which were intended to mitigate the effects of the coronavirus pandemic, and inconsistent education to support these, resulted in delays in diagnosis and initiation of the definitive care and treatment.
Outcome- Minor system of care/service issues - a different plan and/or delivery of care may have resulted in a different outcome, for example systemic factors were identified although there was uncertainty regarding the impact on outcome.
Lessons Learned - Initiation of new ways of working, such as those instigated during the early part of the Coronavirus pandemic, require specific education and training as well as infrastructure. Failure to provide these prior to the initiation of a new service has the potential to result in avoidable adverse outcomes.

4.21 Action taken as a result of complaints received by NHS Grampian and Moray Council during quarter 1 include:

- Transport arranged for patient to transfer out with NHS Grampian
- Communication improvements re constraints caused by pandemic
- Reflection and improvement of record keeping.

HSCM Risk Register

4.22 New risks identified on Datix are discussed at each Clinical and Care Governance Group and CRM. There has been 1 new risk identified as “High” during this reporting period.

4.23 Each Clinical Service Group/Department will highlight risks associated with their service, which are discussed during a reporting session to the HSCM Clinical and Care Governance Group. The risk register has been reviewed with leads given guidance and support to update.

4.24 There are 4 “Very High” risks currently on the register. These are being closely monitored by the CRM and senior leadership team.

Duty of Candour

4.25 Two events were reported during Quarter 1, and are currently being considered for Duty of Candour. A total of 3 events are being considered for Duty of Candour.

4.26 Following investigation, one event previously considered for Duty of Candour in Quarter 4 did not trigger the Organisation duty of Candour.

Items for escalation to the Clinical and Care Governance Committee

4.27 Adult Support and Protection (ASP) – multi-disciplinary joint inspection of adult protection activity in Grampian is expected in 2021/22. A self-assessment return for NHS employed staff was completed and submitted to NHS Grampian Adult Protection Group, on 5 March 2021, as part of a wider programme of work to prepare NHS Grampian for the upcoming joint inspection. A Self Evaluation Improvement Action Plan has been produced and is monitored and actioned through the NHS Grampian adult Support and Protection Group. It is anticipated ASP training for health colleagues will be a priority.

4.28 Adult Support and Protection in Moray – the Adult Support and Protection Improvement Plan is currently being updated, with working groups being established t progress actions. The initial Referral Discussion (IRD) process within in Moray is progressing with supports being identified to advance a single point of contact to develop a Single Point of Contact.

4.29 A multi-agency group is being convened to reinforce a coordinated approach to ASP and self-evaluation within Moray.

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) 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:

- Jeanette Netherwood, 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 sharing and action 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: Pauline Merchant, Clinical Governance Coordinator, HSCM>
Background Papers: with author (data extracted 21.07.21)

Ref:

HSCM Complaints report for April – June 2021 (Quarter 1 2021/22)

Complaints closed in Quarter 1

A total of 19 complaints were closed during Quarter 1, these are outlined below.

Some of these were cross service complaints, with some involvement of HSCM services

	Fully upheld: Complaint is accepted	Partially upheld: Complaint is partly accepted	Not upheld: Complaint is not accepted	Total
Community Hospital Nursing	0	1	0	1
Community Nursing	2	0	4	6
GMED	5	1	1	7
Mental Health - Adult Mental Health	0	0	1	1
Community Care –Assessment	0	1	1	2
Community Care – Self-Directed Support	0	1	0	1
Community Care - Process/ Procedure	1	0	0	1
Total	8	4	7	**19**

HSCM/Local Authority Complaints Closed

N = 4	**Final Response sent**	**%age**
Within 20 days	**3**	75
Within 30 days	**1**	25

HSCM Joint Complaints Closed

N = 19	**Final Response sent**	**%age**	**Final Response uploaded**	**%age**
Within 20 days	**7**	37	**8**	42
Within 30 days	**3**	16	**5**	27
Within 40 days	**3**	16	**4**	21
Greater than 40 days	**6**	31	**2**	12
	19	100	**19**	100

In 9 instances, the response from HSCM//NHS services was uploaded on average 34 days prior to the complaint being finally closed. (Range 6 – 104 days). The time in authorising and sending the final response letter incurs a delay.

Two of the biggest delays were occurred where the complaints were cross service and responses were awaited from other services.

In one instance, the complaint was closed in 57 days, but remains open on the system (217 days) as it later went to SPSO.

Another compliant remained open on the system for a further 61 days whilst a meeting with family was arranged following receipt of the final response letter.

It is evident that complaints from NHS are not being responded within the complaints handling procedure timescales, and work is underway to identify the barriers to this, and to identify where improvements can be made. The majority of delays in closing complaints are also being incurred whilst awaiting responses from other services and in final approval of the response.

Adverse Events

Adverse Events by Category and Level of Review* Reported on Datix (Quarter 1, 2021/22) - **Table 1**

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	Level 1 - significant adverse event analysis and review	Total
Abusive, violent, disruptive or self-harming behaviour	66	0	0	66
Access, Appointment, Admission, Transfer, Discharge (Including Absconders)	12	1	0	13
Accident (Including Falls, Exposure to Blood/Body Fluids, Asbestos, Radiation, Needlesticks or other hazards)	88	1	0	89
Clinical Assessment (Investigations, Images and Lab Tests)	3	0	0	3
Consent, Confidentiality or Communication	9	0	0	9
Diagnosis, failed or delayed	0	2	0	2
Financial loss	2	0	0	2
Fire	3	0	0	3
Implementation of care or ongoing monitoring/review (inc. pressure ulcers)	10	1	0	11
Infrastructure or resources (Staffing, Facilities, Environment, Lifts)	12	1	0	13
Medical device/equipment	2	0	0	2
Medication	23	1	0	24
Other - please specify in description	22	0	0	22
Patient Information (Records, Documents, Test Results, Scans)	7	0	1	8
Security (no longer contains fire)	2	0	0	2
Treatment, Procedure (Incl. Operations or Blood Transfusions etc.)	2	1	0	3
Total	263	8	1	272

Adverse Events by Harm Reported on Datix (Quarter 1, 2021/22) – **Table 2**

	2020/21 Quarter 1	2020/21 Quarter 2	2020/21 Quarter 3	2020/21 Quarter 4	**2021/22 Quarter 1**
Occurrence with no injury, harm or ill-health	169	204	170	222	**193**
Occurrence resulting in injury, harm or ill-health	51	77	73	72	**80**
Near Miss (occurrence prevented)	16	26	35	34	**34**
Property damage or loss	2	5	2	0	**0**
Death	0	0	0	0	**0**
Total	238	312	280	328	**307**

Adverse Events – Occurrence resulting in injury, harm or ill-health (Quarter 1, 2021/22) – **Table 3**

Occurrence resulting in injury, harm or ill-health **Q1 21/22**		**Negligible**	**Minor**	**Moderate**	**Major**	**TOTAL**
Staff	n = 7	3	14	1	0	**18**
Patient	n = 66	4	45	5	1	**55**
Equipment	n = 6	0	1	0	0	**1**
Provision of Service	n = 1	0	6	0	0	**6**
		7	**66**	**6**	**1**	**80**

Adverse Events by Severity Reported on Datix (Quarter 1, 2021/22) – **Table 4**

		2020/21 Quarter 3	**2020/21 Quarter 4**	**2021/22 Quarter 1**
Negligible	No injury or illness, negligible/no disruption to service / no financial loss	215	262	**234**
Minor	Minor injury or illness, short term disruption to service, minor financial loss	60	58	**66**
Moderate	Significant injury, externally reportable e.g. RIDDOR, some disruption to service, significant financial loss	4	7	**6**
Major	Major Injury, sustained loss of services, major financial loss	1	1	**1**
Total		280	328	**307**

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 26 AUGUST 2021**

SUBJECT: **COMPLAINTS REPORT 2020 TO 2021**

BY: **CORPORATE MANAGER**

1. REASON FOR REPORT

1.1. To inform the Committee of the statutory requirements, performance and improvement actions identified in relation to complaints.

2. RECOMMENDATION

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

i) the statutory requirements in relation to production of performance reporting regarding complaints;

ii) the performance information collated in the format of key;

iii) performance indicators, for inclusion in the annual report as attached at APPENDIX 1;

iv) the approach to be adopted to improve performance; and

v) an annual report for April 2020 to March 2021 will be submitted to MIJB in September 2021 for approval prior to publication.

3. BACKGROUND

3.1. This Committee requested specific information relating to complaints at the meeting on 27 May 2021 (para 6 of the minute refers). The information requested was:-

- explanation of the Statutory obligations and if they were being met
- themes emerging from complaints
- how learning from complaints was collated and actioned

3.2. The Scottish Public Services Ombudsman (SPSO) Act 2002 (as amended) provides the legislative basis for SPSO to public the Model Complaints Handling Procedures (MCHP) for bodies under SPSO's jurisdiction.

3.3. The original 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.

3.4. 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 to give public sector organisations time to implement any changes by April 2021. 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.

3.5. The Moray Council Model Complaints Handling Procedure states "The *purpose of the Local Authority MCHP is to provide a standardised approach to dealing with customer complaints across the local authority sector in Scotland. The procedural elements tie in very closely with those of the NHS complaints handling procedure (CHP), where social work or care complaints cut across services, they can still be handled in (much) the same way as other complaints. In particular the aim is to implement a standardised and consistent process for customers to follow which makes it simpler to complain, ensures staff and customer confidence in complaints handling and encourages local authorities to make best use of lessons from complaints*".

3.6. The SPSO are in the process of producing guidance documents in relation to key performance indicators for the Model Complaints Handling Procedures which should be published shortly.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The draft mandatory Key Performance Indicators that will be required as a minimum for inclusion in an Annual Complaints Report to be published by the end of September, have been identified by SPSO as:-

Indicator One	**Learning from complaints** *A statement outlining changes or improvements to services or procedures as a result of consideration of complaints*
Indicator Two	**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 Three	**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 Four	**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 Five	**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*

Information about complaints referred to the ombudsman will also be included along with any complaints made against the MIJB.

4.2. In addition there are another 3 indicators that are recommended:-

Indicator Six	***Raising awareness*** *A statement to report on the actions taken to identify vulnerable and underrepresented groups and raise awareness of, and access to, the complaints handling process with them.*
Indicator Seven	***Staff training in complaint handling*** *A statement to report on levels of staff awareness and training.*
Indicator Eight	***Customer satisfaction with the complaints process*** *A statement to report customer satisfaction with the complaints service provided*

4.3. With regard to indicator 5 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

.

4.4. The MCHP requires reports to be presented to Senior Managers on a quarterly basis outlining the complaints handling performance indicators identified above (indicator 1-5) and the analysis of trends and outcomes of complaints. This will be a change to current practices where complaints are reviewed on a fortnightly basis for progress through the Clinical Risk Management meeting and through quarterly standing agenda items for Practice Governance Board and Clinical and Care Governance Group where there are representations from the senior management team, however in future these reports will also be submitted to Senior Management Team for scrutiny.

4.5. Service managers discuss complaints with their teams as part of their normal business practices. Some examples of good practice: - within Care at home services where all frontline resolutions and complaints are looked at by the appropriate team to identify any learning opportunities and this information is fed to the service management team. GMED have a clinical and governance meeting where they review complaints with their partners to gain shared understanding of impacts on people. The Quality and Patient Safety Committee at Seafield Hospital is proving to be a popular forum and a successful platform for shared learning. While still in its infancy, it is planned that as the forum evolves, it will provide an opportunity for joint training events with colleagues from all disciplines. The standing agenda focusses on all governance aspects including Older People in Acute Hospital inspection programme (OPAH) standard compliance and audit, complaints and risk, DATIX and significant event analysis.

4.6. The information from complaints from April 2020 to March 2021 has been collated and is shown in **APPENDIX 1**. This information will be the basis of the annual report and will be further refined before submission for approval by MIJB in September 2021.

4.7. The analysis of the information for indicator 2 shows that there was a drop in number of complaints received during 2020/21 however due to the 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 which may account for the reduction.

4.8. Of the total number of complaints received (indicator 3) there is a much greater proportion of complaints dealt with at early resolution/frontline stage by the Council employed staff than the NHS staff. This maybe down to the differences in recording systems but will be investigated further to ascertain if there is a reason.

4.9. The main causes of complaints (highlighted in indicator 1) related to communication and procedure and a number of actions were undertaken through the year to apply the learning and reduce the likelihood of reoccurrence. These included:-

- an establishment of monthly multi-disciplinary meetings to monitor care packages and provide a forum to discuss issues raised and development of focussed training for all relevant social work staff with the aim of improving the consistency and quality of engagement with families both during assessment process and pre-discharge care planning.
- changes to recording of meetings on Carefirst to ensure that resource allocation meetings had the necessary information to ensure appropriateness of referrals.
- Establishment of a short life working group with GMED for the dispatching/caseload allocation based on staff and patient feedback to improve process and information flow.
- Case review was held, when there was a placement of an individual that was handled badly, so that learning could be identified and shared.

4.10. In addition there was other more individual learning where specific members of staff were given additional training in respect of standards of communications expected, and the protocol for reviewing an individual's care package. There was a meeting with complainant to explain how the system worked in more detail to their satisfaction.

4.11 If appropriate, a service manager, may decide to record an adverse event as a result of a complaint. By recording incidents in this way details can be recalled and referred to in the future and by analysis of incidents enables teams to learn from events, develop and improve services and identify training needs. Staff are encouraged and supported to report all adverse events; all incidents are taken seriously and reporting enables appropriate surveillance and ensure support systems are in place for staff. For example, monthly educational sessions are held for the Grampian Medical Emergency Department (GMED) to learn from adverse events/complaints and build sustainable connections between GMED clinicians and between the service and wider system. These sessions receive positive feedback and are well attended

4.12. It is anticipated that the number of complaints that will be received during 2021 to 2022 has the potential to be significantly greater than previous years due to people being dissatisfied with the length of time they are required to wait for services or the type of service they are offered. From the data in relation to Indicators 3 and 4 it is clear that HSCM is not meeting the target for response and the average working days to respond far exceed the targets. It is recognised that a significant number of complaints are not responded to within the target of 20 days and, whilst there maybe reasons for this, there is insufficient evidence that people are being kept up to date with progress and improvements need to be made. Furthermore there is a need to ensure that managers are fully aware of the changes that have taken place in relation to the "resolved" classification and the importance of establishing the key focus of the complaint early on to facilitate finding a resolution that is satisfactory to the complainant. To address these issues, following discussion at the Clinical and Care Governance Group, it was decided to hold a workshop in September with managers and staff involved with the complaints process, to:

- Use some examples of recent complaints as case studies to reflect on how they were taken through the process and if there are learning opportunities to take forward. This would include developing a shared

understanding of the recording and reporting of complaints and the flow of information through the system.
- Identification of any opportunities for streamlining processes
- Identify commonly raised questions to see if a "frequently asked questions" document can be produced

4.13. Output from the workshop will be taken forward by the Clinical and Care Governance Group.

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"

Feedback from people is important for organisations to listed and respond to. Complaints are one mechanism for feedback and it is essential that they are dealt with appropriately with lessons learn to ensure that we make best use of the engagement to support the delivery of the outcomes in the Moray Integration Joint Board Strategic Plan specifically in relation to;

- People are safe
- The workforce continually improves

(b) Policy and Legal

The processes set out are in accordance with the legislation identified in section 3.

(c) Financial implications

There are no financial implications as a result of this report

(d) Risk Implications and Mitigation

If we do not listen and learn from complaints there is a risk that we repeat the same mistakes which may affect people and their wellbeing negatively or may be wasteful of resources.

(e) Staffing Implications

There are no staffing implications as a result of this report

(f) Property

There are no property implications as a result of this report

(g) Equalities/Socio Economic Impact

There are no equalities/socio economic implications as a direct result of this report

(h) Consultations

Consultations have taken place with H&SCM Chief Officer, Chief Financial Officer, Head of Service, John Black, Complaints Officer, Moray Council, NHSG and Tracey Sutherland, Committee Officer, Moray Council

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. Monitoring and learning from all feedback is an ongoing process and this report sets out the progress to date and the next steps for improvement.

Author of Report: Jeanette Netherwood & Isla Whyte
Background Papers: With the author
Ref:

Complaints Data (by closed complaints)

2020/21 – Annual Report (01/04/20 – 31/03/2021)

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 it means that there are differences in how the information is reported for some of the indicators.

Datix is used by NHS Grampian and is therefore accessed by NHS staff, Lagan is used by Moray Council and is used by Council staff.

Indicator 1 - 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 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 – Action Taken

	Early resolution	Investigation	Total
Access - Improvements made to service access	0	4	4
Communication - Improvements in communication staff-staff or staff-patient	0	17	17
Education/training of staff	0	5	5
No action required	3	10	13
Policy reviewed	0	1	1
Risk issues identified and passed on	0	1	1
System - Changes to systems	0	2	2
Share lessons with staff/patient/public	0	9	9
Total	3	49	52*

**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

	Early resolution	Investigation	Total
Complaint against service assessment	2	1	3
Complaint against staff	4		4
Other	5	1	6
Process / Procedure	10	5	15
Total	21	7	28

Actions taken by services as learning outcomes included establishment of monthly multi-disciplinary meetings to monitor care packages and provide a forum to discuss and issues raised and development of focussed training for all relevant social work staff with the aim of improving the consistency and quality of engagement with families both during assessment process and pre-discharge care planning. There were changes to recording of meetings on Carefirst to ensure that resource allocation meetings had the necessary information to ensure appropriateness of referrals. In addition, specific members of staff were given additional training in respect of standards of communications expected, and the protocol for reviewing an individual's care package.

Table 2

Complaints Information Extracted from Datix – Action Taken by Service

	Access - Improvements made to service access	Communication - Improvements in communication staff-staff or staff-patient	Education /training of staff	No action required	Policy reviewed	Risk issues identified and passed on	System - Changes to systems	Share lessons with staff/patient/public	Total
Allied Health Professionals	1	2	1	0	1	0	0	1	6
Community Hospital Nursing	0	1	0	0	0	1	0	2	4
Community Nursing	1	4	0	1	0	0	0	1	7
General Practice	0	0	0	1	0	0	0	0	1
GMED	1	7	4	6	0	0	2	5	25
Mental Health - Adult Mental Health	0	1	0	3	0	0	0	0	4
Mental Health - Child and Adolescent	0	0	0	1	0	0	0	0	1
Mental Health - Old Age Psychiatry	1	2	0	0	0	0	0	0	3
Public Health	0	0	0	1	0	0	0	0	1
Total	4	17	5	13	1	1	2	9	52*

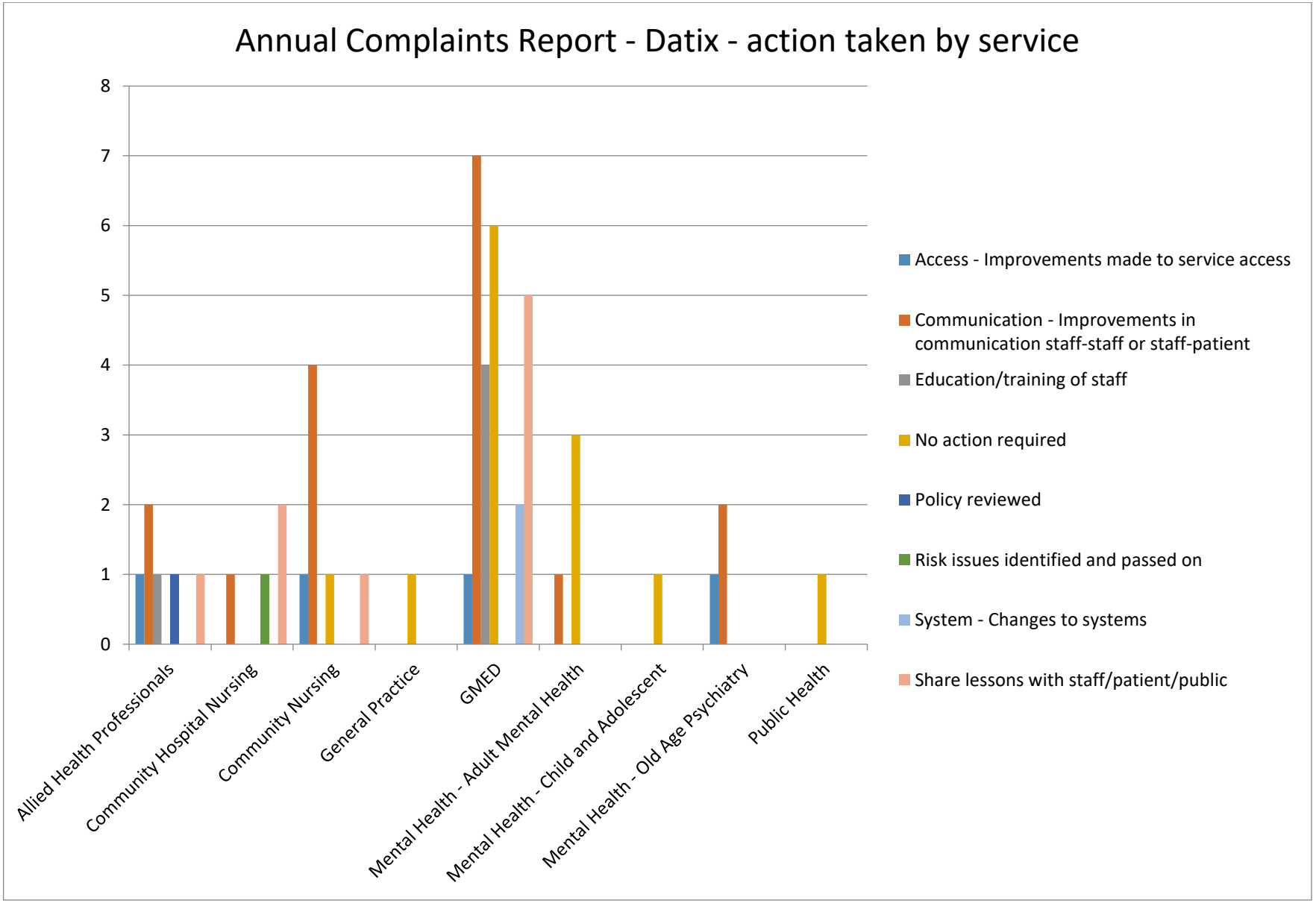
GMED have received the most complaints but that is usual due to the type of service that they provide and they actively review all their complaints on a weekly basis. They established a short life working group to review the dispatching/caseload allocation based on staff and patient feedback to improve process and information flow. They also have established a monthly learning session where topics are discussed that have arisen from complaints or adverse events, that provide a cross-service training opportunity and forms an excellent basis for identification of improvements.

A significant number of the complaints recorded via Datix are related to communication and there has been additional training regarding protocols for how to hold meetings and discussions with people and then the follow up to ensure that there is a shared understanding which should hopefully reduce misunderstandings in future.

Other teams discuss their complaints at their team meetings and discuss any opportunities for improvement or training requirements.

Graph 1

Complaints Information Extracted from Datix – Action Taken by Service



Indicator 2 - 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

System recorded	Early Resolution / Frontline	Investigation	**Total**
NHS - Datix	3	32	35*
Moray Council - Lagan	25	7	28*
Total	28	39	**67**

**Note - 1 rejected on Datix as for NHS 24 not NHSG but included in total figure (35)*
**Note - 4 complaints received into Lagan but not closed during the period included in early resolution figures*

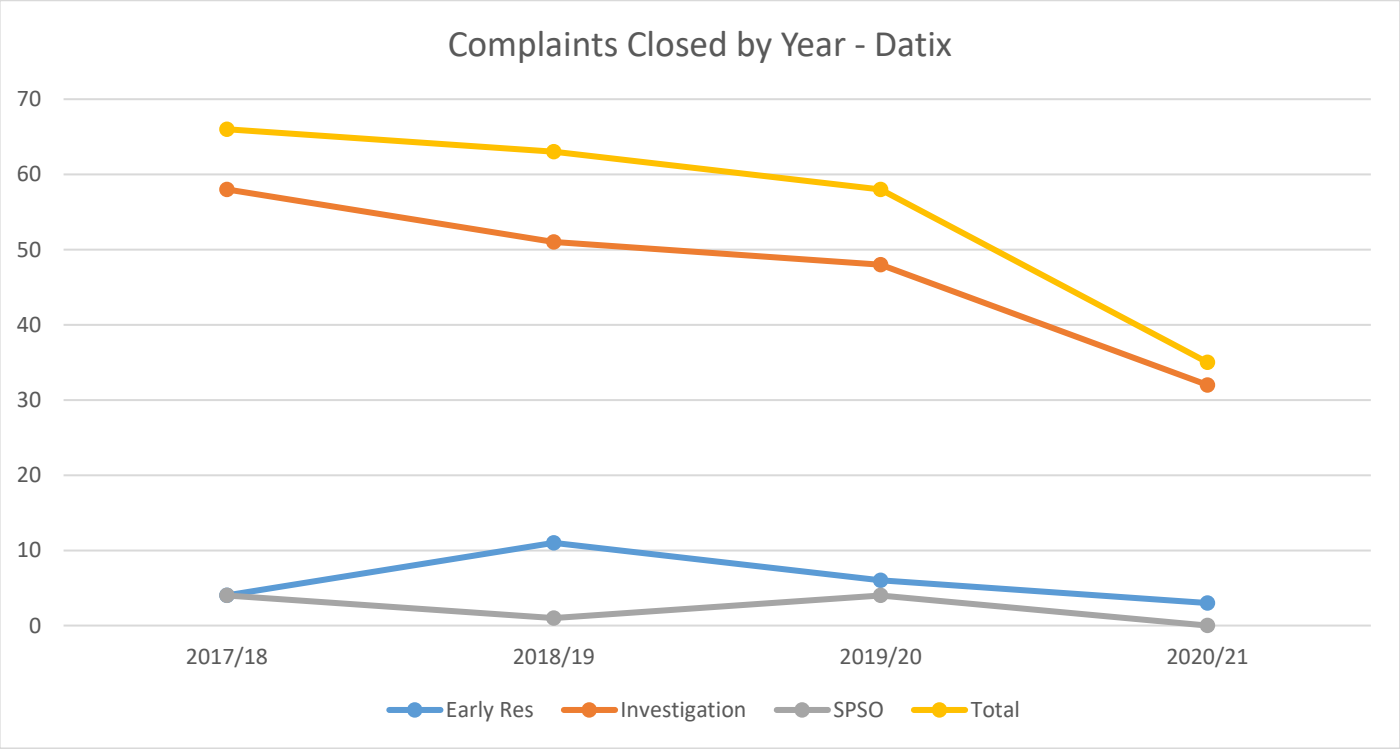
Table 4

	Early resolution	Investigation	Total
Allied Health Professionals	0	2	2
Community Hospital Nursing	0	2	2
Community Nursing	1	4	5
General Practice	0	1	1
GMED	1	15	16
Mental Health - Adult Mental Health	0	5	5
Mental Health - Child and Adolescent	0	1	1
Mental Health - Old Age Psychiatry	0	2	2
Public Health	1	0	1
Access Team	3	0	3
Head of Service	14	3	17
Mental Health – Social Work	1	1	2
Adult Protection	1	0	1
Occupational Therapy	1	0	1
Care at Home	2	1	3
Community Care Finance	2	0	2
Moray East Team – Social work	0	1	1
Moray West Team – Social Work	1	1	2
Total	28	39	67

Datix – Complaints Closed by Year:

Year	Early Resolution	Investigation	Ombudsman	Total
2017/18	4	58	4	66
2018/19	11	51	1	63
2019/20	6	48	4	58
2020/21	3	32	0	35

Graph 2 - Datix – Complaints Closed by Year

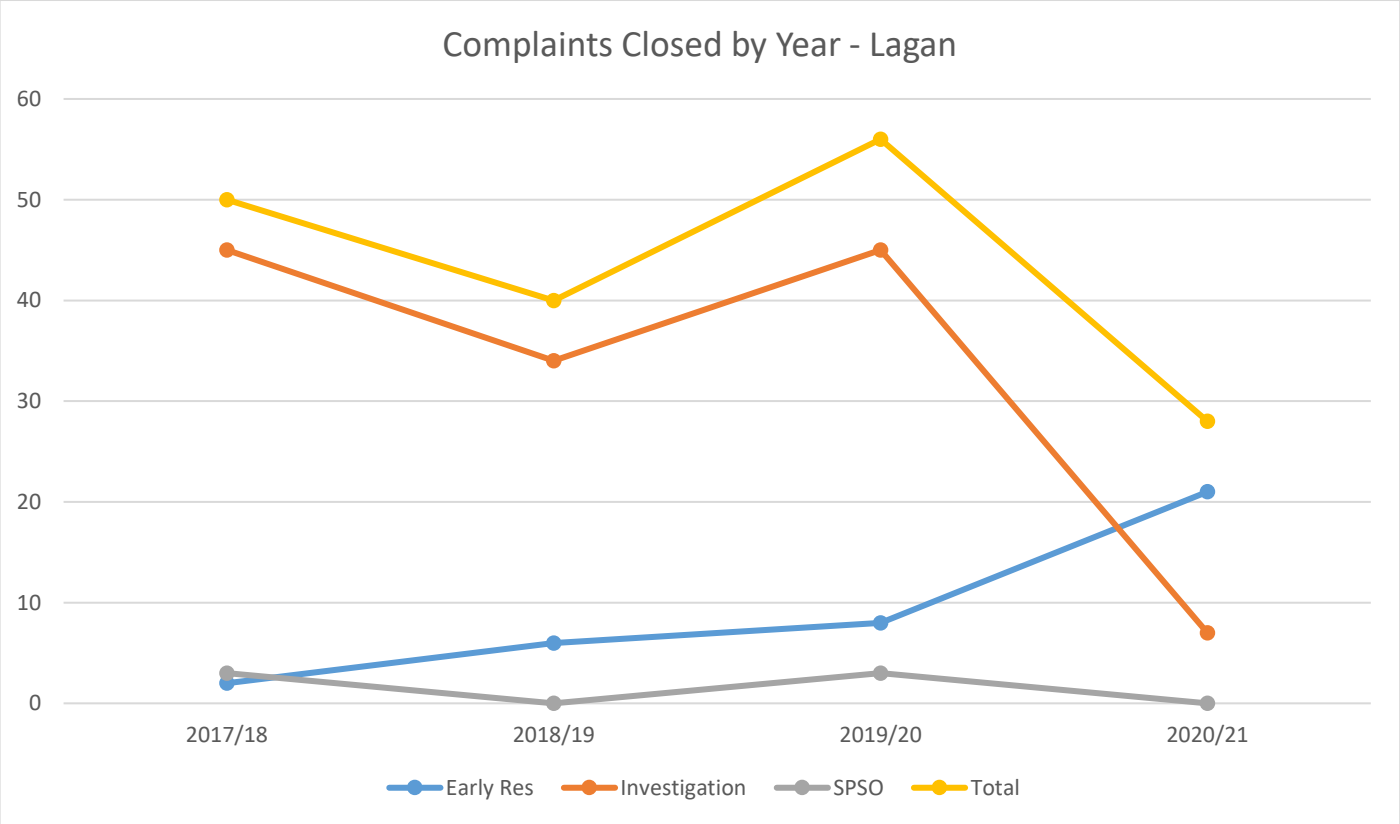


The number of complaints recorded through Datix last year reduce significantly. Due to the pandemic and the impacts and changes to services it is not possible to do a direct comparison to previous years. What is promising is the reduction in the number of complaints that required to be taken to investigation stage although efforts during 2021/22 will be to increase the number of complaints closed and complainants satisfied at early resolution stage.

Lagan - Complaints Closed by Year:

Year	Early Resolution	Investigation	Ombudsman	Total
2017/18	2	45	3	50
2018/19	6	34	0	40
2019/20	8	45	3	56
2020/21	21	7	0	28

Graph 3 - Lagan – Complaints Closed by Year



The number of complaints recorded through Lagan also was half the number in the previous year. What was very promising was the increase in the volume of complaints completed at early resolution stage (circa 60%).

Indicator 3 - 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 with timescale	Investigation within timescale
NHS - Datix	1 out of 3 (33%)	8 out of 32 (25%)
Moray Council - Lagan	4 out of 25 (16%)	1 out of 7 (14%)

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. However during last year we were not able to achieve the targets timescales for responding with over 75% of responses out with target. This may be in part due to the impact of Covid-19 Pandemic as during times of surge, all staff resource was directed on delivering critical functions and responses to communications were not given the same priority. This is a particular target area for improvement and a workshop to review some examples of complaints to conduct case studies will be undertaken in September 2021 to seek 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 4 - The average time in working days for a full response to complaints at each stage

Table 6 – average time in working days to respond

	Frontline	Investigative
NHS - Datix	18 working days	55 working days
Moray Council - Lagan	21 working days	35 working days

Whilst there have been significant improvements in seeking early resolutions to the complaints, we are not achieving this within the set timescales and this is an area that needs significant improvement.

Indicator 5 - 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

71% of complaints were not upheld,

Service	Upheld	Partially Upheld	Not Upheld	Grand Total
Access Team	0	1	2	3
Adult Protection	0	0	1	1
Care at Home	0	0	2	2
Community Care Finance	0	0	2	2
Head of Service	1	3	7	11
Mental Health	0	0	1	1
Occupational Therapy	0	1	0	1
Total	1 (5%)	5 (24%)	15 (71%)	**21**

Table 8 – Stage 2 - Investigative

Service	Upheld	Partially Upheld	Not Upheld	Grand Total
Care At Home	0	1	0	1
Head of Service	0	3	0	3
Mental Health	1	0	0	1
Moray East	0	1	0	1
Moray West	0	1	0	1
Total	1 (14%)	6 (86%)	0	**7**

Combined Statistics - Department/Service

Table 9

Service	Upheld	Partially Upheld	Not Upheld	Grand Total
Access Team	0	1	2	3
Adult Protection	0	0	1	1
Care At Home	0	1	2	3
Community Care Finance	0	0	2	2
Head of Service	1	6	7	14
Mental Health	1	0	1	2
Moray East	0	1	0	1
Moray West	0	1	0	1
Occupational Therapy	0	1	0	1
Total	2 (7%)	11 (39%)	15 (54%)	**28**

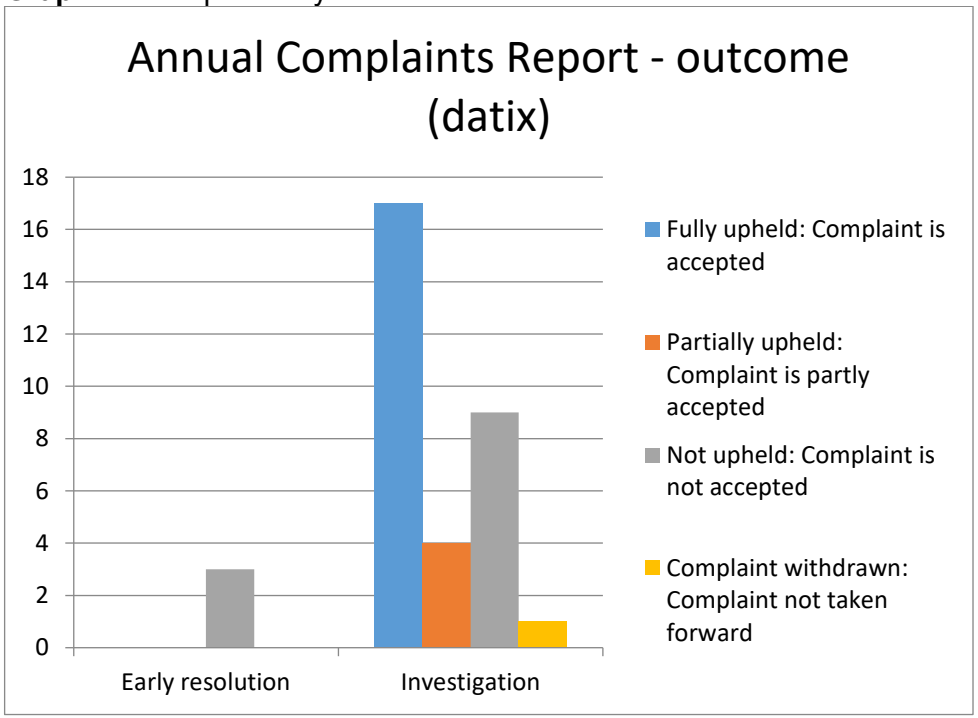
Of the complaints logged in Lagan 7% were upheld, 39% partially upheld and 54% were not upheld overall.
There was a different ratio at the two stages where at stage 1, 71% were not upheld which is positive.
Overall on 2 (7%) out of 28 complaints were upheld although a further 11 were partially upheld.

There were 8 learning outcomes identified and actioned.

It is recognised that there is a need for some refresher training for staff logging complaints on systems to ensure that they complete the necessary fields to facilitate extraction of learning so it can be shared more widely.

Graph 4 below shows the amount of complaints fully upheld as recorded in Datix and whilst the early resolution complaints were not upheld there was a significant proportion 17 (56%) of complaints upheld at investigation stage. The proportion of complaints logged on Datix that are upheld/partially upheld is similar to the complaints upheld/partially upheld that are logged on Lagan.

Graph 4 – complaints by outcome



REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 26 AUGUST 2021**

SUBJECT: **GOVERNANCE AND MONITORING OF CARE HOMES**

BY: **HEAD OF SERVICE STRATEGY AND COMMISSIONING/CHIEF SOCIAL WORK OFFICER**

1. REASON FOR REPORT

1.1. To inform the Committee of the ongoing and evolving governance and monitoring measures in place for care homes in Moray.

2. RECOMMENDATION

2.1. It is recommended that the Clinical and Care Governance Committee note the continuous work to develop the previous and ongoing governance and monitoring of care homes in Moray.

3. BACKGROUND

3.1. There are 13 Older People's Care Homes in Moray, of which 12 are private sector businesses and 1 is a charitable organisation. Individuals are placed in these homes via one of 3 routes, for which there are the following routine assessments:

Route 1 – individuals pay the full amount of their care home fees. They are not necessarily subject to a Social Work Assessment prior to moving into the home, but will be assessed within the first few months for eligibility to Free Personal Care.

Route 2 – individuals pay part of their care home fees and Health & Social Care Moray pay the rest. They are subject to a Social Work Assessment immediately and followed by annual reviews.

Route 3 – individuals do not pay towards their care home fees and Health & Social Care Moray pay the full amount. They are subject to a Social Work Assessment immediately and followed by annual reviews.

3.2. The care home fee rates and contracts are negotiated nationally and administered locally, including operational and contract monitoring.

3.3. Routine governance and contract monitoring includes a number of measures:

- Monthly Complaints, Comments & Incident returns.
- Quarterly Contract Monitoring returns.
- Six monthly Contract Management meetings, which take place on site.
- Quarterly Care Home Owners and Care Home Managers meetings.
- Attendance at any Care Inspectorate feedback sessions.

3.4. Where there are concerns in relation to service delivery are raised by health and social care colleagues that are not adult support & protection (ASP) issues, an enhanced level of contract monitoring is put in place. This includes all of the points contained above in 4.3 in addition to the following:

- An Action Plan, that has to be agreed by the Commissioning Officer, detailing how the home is going to address the concerns, including timescales for progress/completion.
- Additional monitoring specifically in relation to the Action Plan.
- Additional site visits.

3.5. Where the concerns raised relate to an ASP issue the ASP team take the lead, with the Consultant Practitioner being the main point of contact and the Commissioning Team are involved in a supporting capacity. This level of contract monitoring includes all of the points above in addition to the following:

- ASP Consultant Practitioner on site visits
- ASP approval and monitoring of Action Plans.
- Communication with the Care Inspectorate.

3.6. Where there are multiple concerns, recurring concerns of a similar nature, or concerns raised as the result of an inspection by the Care Inspectorate, this leads to consideration of whether a Large Scale Investigation (LSI) is needed and may result in a request that the care home accept a voluntary moratorium until such time that the care home can demonstrate the concerns have been addressed.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. During the Covid-19 pandemic it has not been possible or appropriate for all of the routine governance and monitoring measures to be carried out. However, there has been a suite of governance and monitoring measures established that provided Health & Social Care Moray with a clear, and constantly updating, understanding of the current situation within the care homes. These ensured that any evolving issues and challenges were identified at the earliest possible time and at the same time providing much needed support and guidance to the care homes. The measures are set out below.

4.2. All care homes were required to update their Business Continuity Plans in line with the emerging needs relating to the pandemic and these were submitted to H&SCM in March/April of 2020.

4.3. In July 2020, as required by the First Minister, a framework to support our care homes was established and this included a number of ongoing governance measures. The majority of these are still in place currently as they have proved to be efficient and effective in building very strong working

relationships between the partnership and the providers, while ensuring appropriate governance has remained in place.

4.4. A Care Home Professional Clinical and Care Oversight Group was established. Meeting virtually via Microsoft Teams, originally on a daily basis, and currently meeting three times a week. This group reviews information submitted by the providers and any other relevant information and guidance that impacts positively or negatively on the safe and appropriate delivery of care and support in care homes, and collectively consider any specific governance, monitoring or support measures needed. The membership of this group includes senior managers from social work, commissioning, nursing, health protection and the Care Inspectorate.

4.5. Throughout the height of the pandemic weekly testing for all care home staff was in place, and this has now been escalated to be 2 Lateral Flow tests and one PCR test each week. Residents of one or two care homes per week were tested en masse via Public Health, but this is no longer required.

4.6. A Personal Protection Equipment Hub was established in order to ensure that services, including care homes, had access to the appropriate PPE for safety of staff and residents. This enabled H&SCM to monitor the levels of usage in the sector and ensured the early identification of challenges or difficulties so that appropriate support measures could be put in place.

4.7. Now, longer-term measures need to be considered as a result of the pandemic continuing to impact on the sector, so care homes have again been asked to update, where required, their Business Continuity Plans and submit them to H&SCM. This request was made in July 2021.

4.8. H&SCM put in place a staff deployment plans to be able to make any non-utilised staff available to support any care home who cannot operate safely due to staffing issues relating to the pandemic. Currently the Oversight Group scrutinise staffing issues across all services, including care homes. Issues with staffing have increased as the pandemic has continued, relating to it both directly and indirectly, whereby staff are physically and mentally exhausted after months and months of working under extreme pressure and restrictions, including the need to regularly work additional hours due to staff sickness as well as the amount of additional work required in order to safely deliver care and support.

4.9. Care homes are required to complete daily submissions using a web based governance and monitoring tool designed by Scottish Government and hosted on the TURAS platform. This includes; staffing levels, current and historic infection incidence, levels of compliance with testing guidance, bed availability, and it is monitored by a HSCM Performance Officer and is reported to the Oversight Group.

4.10. A rolling programme of Assurance Visits has been established. Originally carried out by the Chief Nurse and a Social Work Consultant Practitioner and latterly carried out by the Care Homes Nurse and a Social Work Consultant Practitioner. The programme is currently in its fourth cycle through the care homes and is now carried out by the Care Homes Nurse and the Assurance Nurse. These visits look at on the ground, actual hands on delivery of care

and support and identifies any areas of concern that need to be addressed. The outcome of these visits are reported directly to the Oversight Group for governance, monitoring and planning purposes.

4.11. At the start of the pandemic the Care Inspectorate were in direct contact with each care home on a weekly basis. Currently this has been reduced to a monthly basis, however, on site inspections have been re-introduced and are being carried out and a timetable for ongoing visits will be produced for planning purposes going forward. The Care Inspectorate representative on the Oversight Group shares relevant and appropriate information with the group for the management of joined-up governance and monitoring of any emerging of immediate challenges.

4.12. NHSG Public Health were also in direct contact with each care home at least weekly, but more frequently if the RAG status for that home was not green. This has evolved over time and to ensure that over-supporting did not become a significant issue, it has gradually been reduced and now there is a Public Health led meeting on a monthly basis for the care home managers to attend. Throughout all of this time, the Public Health representative on the Oversight Group has reported any relevant information to the group for ongoing, joined-up governance and monitoring.

4.13. Weekly meetings with the Care Home Managers were established by the Senior Commissioning Officer with responsibility for the care homes and were attended by representatives from Social Work, Public Health, H&SCM and the Care Inspectorate. These are still ongoing as they have proved to be an effective and efficient way to build trust and partnership with the providers, as well as identify emerging and immediate challenges/issues and to collectively consider any appropriate actions. Information from this group is reported directly to the Oversight Group for ongoing governance and monitoring.

4.14. Care Home Owners meetings have been re-established and are currently taking place on a quarterly basis. These are led by the Senior Commissioning Officer and the Commissioning Team Manager and any relevant information from these meetings is reported to the Oversight Group.

4.15. Onsight visits by the Commissioning Co-ordinator (Monitoring) have recently been re-introduced. Where required these may be joint visits with the Adult Support and Protection Advanced Practitioner. The outcomes of these visits are reported directly to the allocated Senior Commissioning Officer and the Commissioning Team Manager, who in turn reports any relevant information to the Oversight Group.

4.16. For information purposes, the current RAG status close of business 08/09/2021 for the care homes is below:

Care Home	Previous Day RAG	Current RAG Status	Actions
Abbeyside	Green	Green	No actions
Abbeyvale	Green	Green	No actions
Anderson's	Amber	Amber	1 resident tested , awaiting results
Cathay	Green	Green	No actions
Glenisla	Green	Green	No actions
Meadowlark	Green	Green	No actions
Netherha	Amber	Amber	1 staff tested, awaiting result
Parklands/ Burnbank	Green	Green	1 staff and 1 resident tested, awaiting results.
Speyside	Amber	Amber	1 staff tested, awaiting results
Spynie	Amber	Amber	1 staff tested, awaiting result
The Grove	Green	Green	No actions
Wakefield	Green	Green	No actions
Weston View	Green	Green	No actions
Parkholme	Green	Green	No actions

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, and the previous/ongoing work detailed within it, support the delivery of the Corporate and 10 Year Plans and specifically support meeting the following outcomes in the Moray Integration Joint Board Strategic Plan:

- People are safe
- The workforce continually improves
- Resources are used effectively and efficiently

(b) Policy and Legal

The processes and actions within this report are in line with Scottish Government and Health Protection Scotland guidance and requirements.

(c) Financial implications

There are no financial implications as a result of this report

(d) Risk Implications and Mitigation

Currently any risk implications are mitigated via the support and guidance of NHSG Health Protection Team, The Care Inspectorate, and locally via Care Homes Oversight Group.

(e) Staffing Implications

There are no staffing implications as a result of this report

(f) Property

There are no property implications as a result of this report

(g) Equalities/Socio Economic Impact

There are no equalities/socio economic implications as a direct result of this report

(h) Consultations

Consultations have taken place with; H&SCM Chief Officer, Head of Service Strategy & Commissioning/Chief Social Work Officer, Commissioning Manager, Care Homes Nurse, Health and Social Care Moray and Tracey Sutherland, Committee Officer, Moray Council.

6. CONCLUSION

6.1. The governance and monitoring of care homes has evolved as detailed in this report, and continues to be a live and dynamic process. The relationship between care homes and H&SCM is open, transparent and very strong as a result of the work noted in this report, which supports the ongoing governance and is something that H&SCM are working to ensure that this continues.

Author of Report: Pauline Knox, Senior Commissioning Officer
Background Papers: With the author
Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 26 AUGUST 2021**

SUBJECT: **STRATEGIC RISK REGISTER – AUGUST 2021**

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 August 2021.

2. RECOMMENDATION

2.1 It is recommended that the Clinical and Care Governance Committee (CCG) agree to:

i) consider and note the updated Strategic Risk Register included in APPENDIX 1,

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

iii) consider if this committee wishes to receive this update on a regular basis.

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 At the meeting of this committee on 27 May 2021 (para 9 of the minute refers) it was requested that the strategic risk register be provided to this committee for oversight.

3.3 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 Audit Performance and Risk committee for their oversight and comment.

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

3.5 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 impact of COVID-19 has delayed the development of some aspects of transformation plans as reported to the last meeting of this committee on 24 June 2021 (para 8 on the minute refers). Work overseen by North East Partnership on Home First programme continues to be progressed, in line with our Strategic Plan objectives. As anticipated the numbers of Covid-19 cases in the community continued to increase and there was some impact of staff requiring to self-isolate. However the greatest impact on progression of development work as plan has been the increases in demand for services at all parts of our system, for example at the Emergency Department at Dr Gray's, for social work referrals from the community, requests for Occupational Therapy services and through these processes a resultant increase in demand for care at home services. In addition Primary Care Services have also experienced considerable challenges with the requirement to develop new pathways to support demand. This has impacted on both in hours and out of hours primary care services. These increases in demands for service have arisen at a time where staffing resource has been reduced due to increasing sickness absence, staff vacancies, annual leave and the continued need for some staff redeployment. These aspects continue to impact on delivery of developmental work as staff have to continually adjust to respond to the Covid-19 situation albeit there is development work taking place as teams work collaboratively to address the increases in demand. The continued safe delivery of services is a priority and as such a considerable amount of management time is being directed to support oversight of operational risks to ensure they are managed and prioritised across the whole system.

4.3 There continues to be significant financial risk in the system. As we transition from the additional supports provided as part of the Covid response we are monitoring the position closely and assessing the impact on both short and longer term.

4.4 Recruitment and selection to staff vacancies is proving challenging across services. These challenges remain as previously reported regarding lack of appropriate applications for some posts and also the time taken to for the recruitment process in employing organisations to be followed. There has been significant efforts and collaborative working to streamline processes and align timescales where possible which has resulted in some care at home

appointments being able to commence a couple of weeks earlier than anticipated, which will assist to relieve some particular pressures. In addition there has been an efficient and effective recruitment process for the Discharge to Assess posts which again will assist to relieve specific pressures in the system. There remain some staff redeployments and acting up arrangements in place, such as for some of the vaccination team members, and there will be a period of time before services and staff return to "business as normal" or alternative arrangements are put in place. 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.

4.5 As plans evolve, the Strategic Risk Register will be updated to ensure that it reflects any barriers to realising the ambitions we are not enacting, to achieve 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.

(e) Staffing Implications

There are no additional staffing implications arising from this report. Senior Management Team have considered areas of high risk and are seeking to redeploy staff to address these as a matter of urgency.

(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) Consultations

Consultations have been undertaken with the Senior Management Team, Chief Internal Auditor and Tracey Sutherland, Committee Services Officer and comments have been incorporated in this report.

6. CONCLUSION

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

6.2 The report also outlines the current position in relation to the impact of COVID-19 on progress with transformation plans, and recommends the Board note the revised and updated version of the Strategic Risk Register.

Author of Report: Jeanette Netherwood, Corporate Manager
Background Papers: held by author
Ref:

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT 15 AUGUST 2021

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	**NO CHANGE**
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 been relatively stable and the majority of members have attended several cycles of meetings. An amendment to the Scheme to increase membership by one from each of the partner organisations is being considered by the Scottish Government following 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. In addition weekly meetings of Chair/Vice Chair and Chief Officer are continuing. Progress is being made with the development of the cross system focus on "Home First" and these actions will be incorporated into the Transformation plan that underpins "Partners in Care"	
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 are held for new IJB members. IJB member briefings are held regularly. Conduct and Standards training held for IJB Members in December 2020 with updates provided by Legal Services as appropriate. 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 and wider system re-design and transformation governance structures are being developed for implementation. The work that has been progressed through the Covid19 response has escalated developments in some areas as a matter of priority. This has been done 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 has 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 has been undertaken and will further progress over the next quarter to address this gap.
Current performance:	Scheme of administration is reported when any changes are required. An initial meeting was held with legal advisors to establish the governance requirements for the review of the integration scheme in relation to the proposed delegation of Children's and Criminal 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 Appointment of Standards Officer agreed by IJB September 2020. Members Handbook has been updated and circulated to all members in June 2021. Governance Framework was approved by IJB 28 January 2021 A request to amend the Scheme to increase voting members from 3 to 4 from each partner was submitted to Scottish Government in May 2021, a response was received requiring some other amendments to the previously agreed scheme, which are being addressed and it will then been necessary to submit to Moray Council and NHS Grampian Board for agreement before it can be resubmitted to Scottish Government.
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 has been on hold due to Covid19 and is being restarted but will incorporate the

	changes Covid is causing on ways of working and will recommend a revised way forward. The Strategic Planning and Performance Lead is now taking this forward. The Scheme of Integration requires to be amended to incorporate the agreed increase in membership. The public consultation completed on 5 March 2021 and Moray Council Legal services are progressing with Scottish Government for ratification.

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 2019/20 and 2020/21 settlement saw additional investment for health and social care that was passed through to the MIJB, there remains a significant pressure as much 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 reponse and continue as we continue to remobilise. The full impact is not yet quantifiable. Demand on services is greater than before and the IJB has no remaining general reserves. There is however earmarked reserves of £4.7m that will be used to support the Covid response and Primary Care Improvement Plan The unaudited annual accounts werepresented to the IJB meeting of 24 June 2021 and show a surplus of £6.3m This in the main is derived from late allocation as payment in advance from Scottish Government in relation to Covid spend in 2021/22. The available general reserve of £1.5m has been utilised in balancing the revenue budget for 2021/22 as approved by the IJB in March 2021. Audited Accounts will be presented to the IJB on **25 November 2021 for approval prior to publishing.**	
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 Covid-19 continues to place additional risk on the MIJB finances as we continue through the pandemic and remobilise	
Controls:	Chief Finance Officer appointed - this role is crucial in ensuring sound financial management and supporting financial decision making, budget reporting and escalation. The CFO and Senior Management Team continue to work together to address further savings which will be presented to the Board for approval during the 2021/22 financial year. A revised Financial Framework will be developed during the year to support the emerging situation	
Mitigating Actions:	Risk remains of the challenge that the MIJB can deliver transformation and efficiencies at the pace required. 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 through 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 IJB. The focus for 2021/22 will be close monitoring to assess the continuing impacts of Covid-19 and the costs of remobilisation in addition to identifying further efficiencies and seeking IJB approval
Assurances:	MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.
Gaps in assurance:	None known
Current performance:	For the 2021/22 financial year an overspend will be reported at the end of the first quarter. This will be reported to the IJB on 30 September 2021 In the previous year, reliance has been place on Covid – 19 funding to support under-delivery of savings will has beendrawn-down to create a general reserve. This has been required to support a balanced budget for 2021/22 and it is yet unknown whether SG will provide support for this in the current year.
Comments:	Senior managers to work with Chief Officer and Chief Financial Officer to address the continuing financial challenge, continuing to seek efficiencies and opportunities for real transformation and forecast overspend as we progress through the current pandemic. Through reporting, regular updates will be provided to the MIJB, Moray Council and NHS Grampian as part of the risk sharing arrangement in place.

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 will arise 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	**NO CHANGE**

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 and Social Work are two particular areas experiencing difficulties with obtaining people with the appropriate skills and training. There are additional tasks to be undertaken which include flu immunisation and this is using considerable resource which will not be available to support other frontline services over winter. The roll out of the Covid vaccine 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 and whilst the difficulty with recruitment and retention of staff to caring roles is still being experienced there has not been a direct impact on HSCM teams for additional support from contractors. Neither has Covid 19 cause significant disruption to staffing as a result of positive cases or notification of Test, Trace and Isolate . There have been some achievements in the recent appointment to the Geriatrician post, and recruitment to agreed models for orthapedics, anaesthetics, general surgery and the emergency department in Dr Grays. There is further work being undertaken to develop the model for General medicine. The benefit of these appointments are being felt across the whole system. 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. Committee Officer support has been reinstated for APR and CCG committees with effect from August 2021.
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. There continues to be pressures around Social Work as more requests for assessment are being received from the community and an additional 3.68 FTE have been approved for recruitment for a temporary period to progress outstanding reviews. Management competencies continue to be developed through Kings Fund training although this is 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. This has been expanded to collate details of staff shielding or isolating so arrangements can be made to utilise staff resources as effectively as possible. SMT review vacancies and approve for recruitment. Managers are highlighting any areas of concern and where appropriate this is identified in operational risk registers. HSCM services have commenced twice 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 have been updated and approved by MIJB in November 2019 and they are being progressed by the Workforce Forum. Workforce planning has recommenced and an initial draft was prepared and submitted in April 2021. This will be taken forward alongside plans for NSHG and Moray Council with a detailed version being prepared for March 2022. 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. Close monitoring of Covid infection rates and potential impacts for services are considered at the weekly Response Group meeting.
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 has been in place over the whole period of the Covid19 pandemic providing focussed leadership around emerging issues and resolving them.

Gaps in assurance:	Further work required to develop workforce plans to reflect strategic plan implementation programmes once they are agreed.
Current performance:	The full IMatter surveys did not take place during 2020 however an IMatter pulse survey was undertaken in September 2020 to get a snap shot of what staff are feeling. Results were published 20 November 2020 and although there was a lower response rate of the 36% the "working within the organisation satisfaction" score was 6.91 compared with 6.94 in 2019. Work is underway in preparation fo the Imatter survey that will take place during July/August 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.
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. Collaborative working has resulted in streamlining the appointment and training of 10 Care at Home staff to which will enable them to start their role on 9 August 2021, a couple of weeks earlier than originally envisaged. 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.

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	**INCREASING**
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.	

	The Third Sector rep stood down from MIJB and the substitute is only able to commit to attending until August 2021 so there is a need to recruit. 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. Traditional methods of engagement are not possible at present as social distancing rules apply however alternative mechanisms for engaging with stakeholders are being used along with social media
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 2019/20 was published in August 2020 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 and Keith with information being made available to stakeholders and the wider public via HSCM website. Participation of stakeholders in Home First project meetings.
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. Annual Performance Report for 2019/20 published in August 2020.

	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 are 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.
Current performance:	Communications Strategy was reviewed approved by IJB November 2019. Annual Performance Report 2019/20 published August 2020. Audited Accounts for 2019/20 were publicised by deadline 30 September 2020 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. Staff have been involved in co-ordinating services for and communicating with shielded and vulnerable people.
Comments:	A communication cell was established as part of the Local Resilience Partnership 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. HSCM did not have a collectively approved list of critical functions at the start of the response however this was quickly completed and used to prioritise allocation of resources to the response. This list has been recently reviewed to take into account remobilised services and the winter/surge action plan has been further defined and implemented Whilst the rates of Covid infection in Moray at the moment are relatively low the situation could change. Risk identification, assessment and initial response plans have been developed for potential impacts across the whole system. MIJB will be redefined as a Category 1 responder under the Civil Contingencies (Scotland) Act and there are additional requirements for preparadness 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/Surge Plan updated and was tested alongside NHSG plans for winter with participation from officers in cross system table top exercises. Further work is being undertaken to identify learning from recent incidents to strengthen plans. 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 recent incidents such as Gas outages in Keith and Covid response – debriefs carried out and learning identified	
Mitigating Actions:	Information from the updated BIA/BCP has informed elements of the Winter Plan (Surge 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.	

	NHS Grampian have amended their approach to Pandemic preparation so HSCM Pandemic plan requires redrafting and testing Lesson learnt from the response to Covid will be incorporated into the Surge (Winter) Plan and training needs identified will be addressed. 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 Covid-19 and is engaged with NHSG emergency planning arrangements and Council Response and Recovery management team to be ready to escalate response if required. There is work underway with partners 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 would aid communication and understanding.
Assurances:	Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny.
Gaps in assurance:	Recent experience has highlighted the need for additional staff to be trained to be control centre managers, loggists and 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 more robust arrangement for out of hours contact and clarity of roles and responsibilities across the system which is being progressed with partners in Moray. Some table top exercises have been completed but the intended programme for 2020 will require to be rescheduled once we are out of response phase. 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. Pandemic flu plans will require to be updated with the learning from this incident The debrief reports following the gas outages from a Moray perspective and the Grampian Local Resilience Partnership (LRP), highlighted some issues for clarification in relation to the Care for People agenda. To address the local issues ameeting has taken place with representation from Moray Council and HSCM and steps to re-establish the Care for

	People group and update the Care for People response plan are in progress. The next meeting will be in September 2021.
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. Annual report on progress against NHS resilience standards was reviewed by APR committee on 25 March 2021.
Comments:	Once the response phase is complete the HSCM Civil Contingencies group will schedule and review progress in achieving the NHSG resilience standards, reporting updates to System Leadership Group.

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.	
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 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. 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 was meeting daily but now three times a week 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	

	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. There has been a reduction in staff resources around clinical and care governance due to the need to deploy staff to the vaccination team. This is being addressed.
Current performance:	External inspection reports are reviewed and actions arising are allocated to officers for taking forward. A summary of inspections was included in the Annual Performance report in 2020.
Comments:	No major concerns have been identified for HSCM services in any audits or inspections this year. The equipment store has received a follow up internal audit and the initial verbal feedback was positive.

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 fluctuated over the last two months but reduced in recent weeks and has reflected the sustained focus and collective efforts by all those working in the pathway. However this is a complex area and will require continued effort to continue 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 Transformation Plan being developed. 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.
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 being circulated daily to all managers in a "Performance Flow" dashboard 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.
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. Progress will be reported to future Board meetings.

Current performance:	Covid19 has 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:	Work has progressed with development of performance monitoring and reporting of key performance indicators for locality managers. The delayed discharge group has produced an action plan for implementation and progress is being made. Practice Governance have been reviewing their operational performance requirements. 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.

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 is to be refreshed and re-launched and key work is being progressed that will report into this forum. This will provide as structure for oversight, prioritisation and assurance in relation to key developments, their fit with IJB strategy and enabling elements. The appointment of the Strategic Planning and Performance Lead provides additional 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 and risk assessments are completed and assessments have been or are in the process of being reviewed	

	to ensure equality. The restrictions of social distancing on services mean that capacity for services is impacted which means that service users will not have the same level as before Covid however it is anticipated that a hybrid service will be offered which will facilitate tailoring of services to meet specific individual outcomes where this is appropriate. The time period and extent of Covid 19 the impact on the population of Moray will not be fully understood until well after the response is over. 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 and it is hoped that this progress can be built on
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:	Home First strategic theme is being progressed across the whole system and a local Home First Group is meeting fortnightly. The Home First Transformation Board has also been established for Grampian – the output of these meetings will go through appropriate governance frameworks. A newsletter is being produced to keep staff and partners informed. 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 established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters. Linkages to Infrastructure board and Information sharing groups have been established albeit these meetings are not taking place regularly at the moment

	Data sharing groups for Grampian and Health and Social Care Moray have been established and meetings were held regularly but have not taken place for several months due to Covid. These meetings have oversight of any issues arising from Data protection and GDPR matters from either Council or NHS systems.
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 to be documented. 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. Meetings have not been taking place due to Covid.
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. The changes required to places of work as a result of Covid19 continue to restrict the number of people that can use an office. These decisions are being made by NHSG and Moray Council and we await their development of policy regarding workspace and availability of facilities going forward as highlighted in the Premises Strategy report to MIJB in May 2021. NHSG have advised that staff should aim to work from home until December 2021 although and update will be provided in August 2021. 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. Staff requiring mobile technology have now been provided with it and many staff are working from home. This is a necessity where the number of desks available in offices has been reduced due to implementation of social distancing guidance. There is still an issue with availability of kit for NHS employed staff which has been escalated	
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 are required (through and automated process) to confirm they have read these every 6 months 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.
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 Interim Infrastructure Manager in post and linking into other Infrastructure groups within NHSG & Moray Council to ensure level of 'gatekeeping'. Dr Gray's site development plan is being produced collaboratively with input from NHSG and HSCM management Work is progressing on identification of needs for some services with regard to accommodation which will be communicated with partners to find the most effective solution.
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 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:	The Infrastructure Board is currently suspended. Its purpose is for highlights/exceptions to be taken to SLG for communication and information purposes.

	Access to support for development of HSCM priorities is difficult at time because projects/requests are prioritised against all other services in the partner organisations. The challenges and impact on the ability to adopt efficient working processes for HSCM staff and managers whilst have to use networks/systems from two organisations, which cannot be accessed by all members of teams due to data sharing, matters is very significant.
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