Clinical and Care Governance Committee

Thursday, 30 November 2023

Council Chambers

NOTICE IS HEREBY GIVEN that a Meeting of the **Clinical and Care Governance Committee, Council Chambers**, **Council Office, High Street, Elgin, IV30 1BX** on **Thursday, 30 November 2023** at **14:00** to consider the business noted below.

AGENDA

1.	**Welcome and Apologies**	
2.	**Declaration of Member's Interests**	
3.	**Minutes of meeting of 31 August 2023**	**4 - 8**
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	Leadership and Accountability	
5.	**Strategic Risk Register**	**10 - 38**
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	Effective Communication and Information	
7.	**Complaints Report for Quarter 2 2023-2024**	**55 - 70**

8.	**Inspection of Fostering, Adoption and Adult Placement June-July 2023**	71 - 181
9.	**Drug Related Deaths in Moray**	182 - 184
	Safe and Effective Practice	
10.	**Health and Social Care Moray Clinical and Care Governance Group Escalation Report**	185 - 197
11.	**Community Occupational Therapy Service**	198 - 203
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12.	**Recommended Allowances for Kinship and Foster Carers**	204 - 208
13.	**Items for Escalation to MIJB**	

MORAY INTEGRATION JOINT BOARD

SEDERUNT

Mr Derick Murray (Chair)

Councillor Peter Bloomfield (Voting Member)
Councillor Scott Lawrence (Voting Member)

Mr Ivan Augustus (Non-Voting Member)
Mr Graham Hilditch (Non-Voting Member)
Professor Duff Bruce (Non-Voting Member)
Dr Robert Lockhart (Non-Voting Member)
Ms Elizabeth Robinson (Non-Voting Member)
Dr Malcolm Simmons (Non-Voting Member)
Ms Tracy Stephen (Non-Voting Member)
Mr Kevin Todd (Non-Voting Member)

Clerk Name:	Caroline O'Connor
Clerk Telephone:	07779 999296
Clerk Email:	committee.services@moray.gov.uk

MINUTE OF MEETING OF THE CLINICAL AND CARE GOVERNANCE COMMITTEE

Thursday, 31 August 2023

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

PRESENT

Mr Ivan Augustus, Professor Siladitya Bhattacharya, Councillor Peter Bloomfield, Mr Simon Bokor-Ingram, Mr Graham Hilditch, Councillor Scott Lawrence, Dr Robert Lockhart, Mr Derick Murray, Ms Deborah O'Shea, Ms Fiona Robertson, Dr Malcolm Simmons, Ms Tracy Stephen, Mr Kevin Todd

APOLOGIES

Professor Duff Bruce, Mr Sean Coady, Ms Elizabeth Robinson, Mrs Val Thatcher

IN ATTENDANCE

Bridget Coutts, Lead Nurse, GMED, Shelley Taylor, Service Manager Children and Families, Vicky Low, Interim Public Protection Lead Officer, Rosemary Reeve, Interim Primary Care Development Manager, Michelle Fleming, Self Directed Support and Unpaid Carers Officer, Fiona Robertson, Chief Nurse - Moray, Laura Stevenson, Dental Clinical Lead and the Democratic Services Manager.

1. Chair

The meeting was chaired by Mr Derick Murray.

2. Declaration of Member's Interests

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

3. Action Log - 25 May 2023

The Action Log of the meeting of 25 May 2023 was discussed and updated.

4. Minutes of meeting of 25 May 2023

The minute of the meeting of 25 May 2023 was submitted and approved, subject to an amendment at para 6 where it should read a report back to the Clinical Care and Governance Committee and not Audit Performance and Risk.

5. Strategic Risk Register

A report by the Chief Officer provided an overview of the Clinical and Care Governance Committee of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated in August 2023.

Mr Augustus, Carers Representative queried whether Unpaid Carers should be included as a risk at a strategic level as a breakdown in care provided by unpaid carers would result in care having to be provided from another source.

In response, the Chief Officer agreed that the risk could be woven into the Risk Register.

Following further consideration the Committee agreed to note:

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

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

6. Quarter 1 Complaints Report

A report by the Clinical and Care Governance Group Co-Chairs informed the Committee of complaints reported and closed during Quarter 1 (1 April 2023 - 30 June 2023).

Mr Augustus, Carers Representative sought clarification on how easy it is for the public to complain as he has had people come to him not knowing where to go to complain.

In response the Head of Service confirmed that a lot of work has been done within Children and Families and Justice Social Work to improve and highlight how members of the public can complain and this is something that could be rolled out over Adult Services.

Following consideration, the Committee agreed to note the totals, lessons learned, response times and actions taken for complaints completed within the last quarter.

7. Clinical and Care Governance Group Escalation Report

A report by the Chief Nurse, Moray informed the Committee of progress and exceptions reported to the Clinical and Care Governance Group since the last report to Committee in May 2023. The Chief Nurse, Moray updated the Committee to note that 30 new graduate nurses will be starting employment in Moray, most will be working in Dr Gray's Hospital in Elgin but a number will be working in the community.

Councillor Lawrence sought an update on the funding carried forward to be used to provide suitable accommodation for the Moray Integrated Drugs and Alcohol Service and sought clarification on whether there was a requirement to return the funding if not spent.

In response, the Chief Officer confirmed that options for premises are being looked at but there are difficulties in finding the suitable premises. He further stated that there is a risk that the money will need to be returned if it is not spent, however given that tackling drugs and alcohol issues is a priority for the Scottish Government it is hoped there would be some leeway with the funding.

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

8. Progress Update in Relation to Unpaid Carers Strategy 2023-27

A report by the Self Directed Support and Unpaid Carer Officer informed the Committee of progress of the current work being undertaken inline with the Moray Carers Strategy 2023-26 Implementation Plan.

Mr Augustus, Carers Representative and Dr Simmons sought agreement for the Improvement Plan to be presented to the Committee on a regular basis.

The Chair agreed to discuss frequency of reporting with the Chief Officer and Self Directed Support and Unpaid Carer Officer following the meeting.

Following consideration the Committee agreed to note:

i) the current progress relating to the Carers Strategy Implementation Plan; and

ii) the impact on unpaid carers in Moray.

9. Adult Support and Protection Multi Agency Improvement Plan

A report by the Interim Public Protection Lead Officer updated the Committee on progress against the Adult Support and Protection Multi-agency Improvement Plan, since the last update provided in may 2023.

Following consideration the Committee agreed to note:

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

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

iii) Phase 2 of Adult Support and Protection Activity intention; and

iv) that further updates will be provided to the next Committee meeting.

10. Out of Hours Nursing Service

A report by the Chief Nurse, Moray informed the Committee of the current and emerging situation regarding the Out of Hours Rapid Response Nursing Service currently hosted by Aberdeenshire and delivered by Marie Curie across Moray and Aberdeenshire.

Following consideration the Committee agreed to note:

i) that notice has been given by Marie Curie in relation to the cessation of the Rapid Response Out of Hours Nursing Service aspect of the current contract as of 30 September 2023;

ii) the requirement for NHS Grampian to deliver an Out of Hours Nursing Service across Aberdeenshire and Moray in a two phased approach with the first priority being to ensure that there is continuity of service provision beyond the notice period of 30 September 2023 for a 6 month period to allow a full review of the service delivery model;

iii) Phase 1 - it is proposed that NHS Grampian deliver the joint Moray and Aberdeenshire Model as an "in-house" service with the addition of a nursing triage support aligned with the GMED service to support right care, right time and the right person approach thereby improving the current Out of Hours Nursing Service; and

iv) Phase 2 - it is proposed that NHS Grampian, during Phase 1, review the full service delivery model and consider a standalone Moray Out Of Hours Nursing Care Service based on population need, geographical spread and how this will align with a full 24 hour Nursing Care Service.

11. NHS Dental Provision in Moray

A report by the Dental Clinical Lead informed the Committee about the current status of NHS dental provision in Moray.

Following consideration the Committee agreed to note the current challenges facing NHS dentistry in Moray and nationally.

12. Moray Daytime Unscheduled Care Service

A report by the Head of Service informed the Committee regarding progress made in relation to Moray Daytime Unscheduled Care Service 10 week test of change (January - March 2023).

Following consideration the Committee agreed to note:

i) the evaluation made in relation to the test of change; and

ii) that the findings will be considered in the winter planning for 2023/24 and incorporated in the General Practice (GP) Vision Project, looking at GP services in their entirety.

13. Primary Care Minor Surgery

A report by the Primary Care Development Manager informed the Committee of the current position regarding the Moray Primary Care Minor Surgery Service.

Following consideration the Committee agreed to note the current position of the Primary Care Minor Surgery Service.

14. The Children's Services Plan

A report by the Service Manager, Children and Families asked the Committee to note the strategic intent of the Children's Services Plan 2023-26, following delegation of Children and Families and Justice Social Work Services to the Moray Integration Joint Board (MIJB) on 16 March 2023.

Following consideration the Committee agreed to note:

i) the Children's Services Plan 2023-26 at Appendix 1; and

ii) that an Annual Progress Report will be presented to Committee for noting.

15. Health and Social Care Moray Annual Complaints Report 2022-23

A report by the Chief Nurse, Moray provided the Committee with the Draft Health and Social Care Moray (HSCM) Annual Complaints Report for 2022/23.

Following consideration the Committee agreed to:

i) note the contents of the annual report; and

ii) request the annual report be submitted to Moray Integration Joint Board in September for approval prior to publication.

16. Duty of Candour Annual Report 2022-23

A report by the Chief Nurse, Moray updated the Committee on the Draft Duty of Candour Annual Report for the year 2022/23.

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

17. Items for Escalation to MIJB

The Committee noted that there were no items for escalation to the Moray Integration Joint Board.

MEETING OF MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE

THURSDAY 31 AUGUST 2023

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY	**UPDATE NOVEMBER 2023**
1.	Strategic Risk Register	Unpaid Carers to be woven into the risk register at a strategic level.	March 2024	Corporate Manager	Work to commence on refreshing the Risk Register. Agreed any emerging risks will be presented as soon as possible.
2.	Quarter 1 Complaints Report	Work to be done to improve the visibility on how to complain.	November	Corporate Manager	Update provided in Q2 Complaints report on today's agenda
3.	Progress Update in Relation to Unpaid Carers Strategy 2023-27	Chair, Chief Officer and Self Directed Support and Unpaid Carer Officer to discuss and agree the frequency of the progress reports to Committee.	November	Chief Officer	Agreed next update will be presented to Cttee March 2024

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 30 NOVEMBER 2023**

SUBJECT: **STRATEGIC RISK REGISTER**

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 September 2023.

2. RECOMMENDATION

2.1 It is recommended that Committee agree to:

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

ii) note that the Audit, Performance and Risk Committee have agreed to a change to the reporting schedule of the Strategic Risk Register, allowing to report biannually instead of quarterly. This will allow time for development, planning and improvement of the Register content; and

iii) note that any significant changes to the register outwith the reporting cycle would be presented at the first opportunity.

3. BACKGROUND

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

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

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

3.4 The Strategic Risks received an initial review to ensure they align to the Moray Partners in Care 2022-2032 Strategic Plan which was agreed at MIJB on 24 November 2022 (para 14 of the minute refers).

3.5 The Audit, Performance and Risk Committee agreed to a change in the reporting timetable on 26 October 2023 (para 8 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 recovery from the Covid-19 pandemic continues. However, there has not been any relief in the system, and it continues to challenge an already pressured system.

4.3 The senior leadership teams continually consider the appetite for risk whilst planning and effecting transformational change and redesign, despite operating within a very finite budget.

4.4 Work continues across teams to ensure the Risk Register is updated in the timescales dictated by the criteria. Work continues to support teams with this.

4.5 Mapping of the recently delegated services is required to ensure all statutory and regulatory governance arrangements are being met, without unnecessary duplication.

4.6 There is significant financial risk in the system. A report was presented to MIJB on 28 September 2023 (para 5 of the minute refers), showing an overall overspend of £5,068,191 on core services. This poses a significant complexity to service planning and recruitment.

4.7 Recruitment and retention continues to provide challenges across all disciplines.

4.8 Annual winter planning has commenced across operational services ensuring they interlink with those of partners, whilst addressing the outcomes set by Scottish Government.

4.9 Work continues to give partnership wide overview of all operational risk registers.

4.10 The absence of a Strategy and Planning Lead will likely cause disruption to the many transformation plans that are currently ongoing. SMT will plan, monitor and mitigate this going forward.

4.11 The continued safe delivery of services is a priority and as such, dedicated management time is being directed to support oversight of operational risks. The Grampian Operational Escalation System (GOPES) continues to be utilised to assist in the identification of pressure points across the whole system so that they can be addressed and prioritised appropriately. These principals continue to be revisited across the system in Grampian.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022-2032"
The MIJB requires effective governance arrangements for those services and functions delegated to it and Risk Management systems are integral to this.

(b) Policy and Legal
As set out in the terms of reference, the Board has responsibility to provide assurance of the adequacy of the risk management framework.

There are no legal implications arising from this report.

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

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

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

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

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

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

(i) Directions
None arising from this report.

(j) Consultations
Consultation on this report has taken place with SMT.

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 outlines the current position and recommends the Committee note the updated version of the Strategic Risk Register.

6.3 The report recommends changing the reporting schedule to biannually.

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

APPENDIX 1

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT SEPTEMBER 2023

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 2022 to 2032" was approved by MIJB in November 2022. An amendment to the Scheme to increase membership by one from each of the partner organisations was ratified in March 2022 by the Scottish Government following due process and approval by Moray Council and NHS Grampian Board. There is a schedule of weekly meetings with the Chair/Vice Chair, Chief Officer, Chief Financial Officer, Strategic Planning Lead and Corporate Manager. The delivery plan for the new Strategic Plan "Partners in Care" 2022-32 was presented to MIJB in September 2023.	
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" 2022-32 • 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 any new IJB members. Further sessions are arranged for new appointees. Conduct and Standards training held for IJB Members in June 2022 provided by Legal Services. SMT regular meetings and directing managers and teams to focus on priorities. Regular development sessions held with IJB and System Leadership Group Strategic Plan and locality management structure is in place.	

Assurances:	• Audit, Performance and Risk Committee oversight and scrutiny. • Internal Audit function and Reporting • Reporting to Board. • The Moray Transformation Board has recently recommenced and will support an oversight of planned business across HSCM.
Gaps in assurance:	The new strategic delivery plan and will incorporate the work being taken forward for Self-Directed support, Hospital at Home and Locality Planning. Mapping of the recently delegated services will take place to ensure the statutory governance requirements and those of MIJB are met.
Current performance:	The Scheme of Administration is reported when any changes are required. Legal advisors are currently working on the requirements to the integration scheme in relation to the proposed The integrated scheme of delegation of Children's and Families and Justice Services was presented and accepted by MIJB on 26th January 2023. The Governance Framework was approved by IJB 28 January 2021. Re-appointment of Standards Officer agreed by IJB 31 March 2022. Members Handbook has been updated and circulated to all members in June 2022.
Comments:	Strategic Planning and Commissioning Group approved the generic Terms of Reference and Chairs of the transformation boards at the meeting on 19 December 2019.-The Interim Strategy and Planning Lead is now taking this forward and prioritising and focusing on strategic planning and priorities over the short and longer term.

2		
Description of Risk: *Financial*	There is a risk of MIJB financial failure in that the demand for services outstrips available financial resources. Financial pressures being experienced both by the funding Partners and Community Planning Partners will directly impact on decision making and prioritisation of MIJB.	
Lead:	Chief Officer/Chief Financial Officer	
Risk Rating:	Low/ medium/ high/ very high	**VERY HIGH**
Risk Movement:	Increase/ decrease/ no change	**INCREASE**
Rationale for Risk Rating:	The 2023/24 settlement only saw funding for recurring commitments. There remains a significant pressure due to the recurring core overspend, since most of the new investment related to new commitments. Financial settlements are set to continue on a one year only basis, which does not support sound financial planning. In addition, the carried forward ear marked reserves have been significantly reduced with the clawback of the Covid reserve and reduction of the PSIF funding in 2022/23 . The impact of which will be to reduce the level of ear marked reserves in the MIJB. The Revenue Budget 2023/24 was approved by MIJB on 30 March 2023 as a balanced budget. A significant ambitious savings plan of £4.1 million was approved. Additional Scottish Government funding was provided again for 2023/24, this is to meet additional recurring policy commitments in respect of adult social care pay uplift for externally provided services and free personal and nursing care rates. As at quarter 1 a forecasted overspend of £3.7m is expected and with both partners having financial challenges a recovery plan and additional savings will be required to balance the budget. The update medium Term Financial Framework was presented as part of the budget papers on the 30th March 2023 this will be further reviewed during the 2023/24 year to ensure alignment with the recently reviewed Strategic Plan and for the delegation of Childrens Services and Criminal Justice.	
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	
Controls:	There is an interim arrangement for CFO cover from Moray Council. Permanent recruitment efforts have not been successful. The Chief Officer is working with both the Council and NHS Finance Leads to secure a longer term interim arrangement. The CFO and Senior Management Team have worked together to address ~~further~~ savings which were approved by the Board as part of the budget setting procedures for 2023/24. This will be a focus of continuous review to ensure any investment is made taking cognisance of existing budget pressures. A revised Financial Framework was presented to	

	the MIJB on 30 March 2023, and a further review will take place during the year. The Senior Management Team will continue to consider and plan for the financial challenges for 2023/24 and beyond.
Mitigating Actions:	Risk remains of the challenge that the MIJB can deliver transformation and efficiencies at the pace required whilst dealing with the emerging financial pressures. 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 regularly engage in finance discussions with key personnel of both NHS Grampian and Moray Council. Chief Officer and CFO will continue to engage with the partner organisations in respect of the financial position throughout the year. Cross partnership performance meetings are in with partner CEOs, Finance Directors and the Chair/Vice Chair of the MIJB.
Assurances:	MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.
Gaps in assurance:	None known
Current performance:	An overspend of £2,306,993 on Core services as at 30 June 2023 and for the 2023/24 financial year a provisional forecast of a £3,729,822 overspend was reported to the IJB on 28 September 2023.
Comments:	Senior managers continue to work with Chief Officer and Chief Financial Officer to address the continuing financial challenge, continuing to seek efficiencies and opportunities for real transformation as we look to make efficient and effective investment in services that are truly transformational. There are additional pressures from the cost of living crisis, increasing energy bills, inflation and staff pay awards.

3		
Description of Risk: *Human Resources (People):*	Inability to recruit and retain qualified and experienced staff to provide and maintain sustainable, safe care, whilst ensuring staff are fully able to manage change resulting from response to external factors such as the impact of Covid and the actions that arose from the recommendations from the Independent Review of Adult Social Care 2021.	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**HIGH**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	There continues to be issues with recruitment to front line services that require specific skills and experience. This continues to place pressure on existing staff. Allied Health Professions, Social Work and Nursing are some of the particular areas experiencing difficulties with obtaining people with the appropriate skills and training. Care at Home staffing levels are pressured for Internal services and externally with local providers all experiencing the same difficulties. There are also impacts on recruitment of Dentists and other graduates arising from Covid as the number graduating reduced during that period. The various impacts of Covid-19 has placed a significant strain on the Partnerships resources across frontline and support functions and this has resulted in delays for the progress of projects relating to the achievement of strategic objectives. HSCM continues to review the large number of fixed term and seconded posts. This will continue as temporary contracts conclude. It is hoped that this will improve some of the instability teams felt during the pandemic response. This will also allow consideration of post redesign, service needs and potential financial savings. This will continue to be reviewed by the Senior Management Team. Care Homes in Moray continue to face difficulties with recruitment and retention of staff. Efforts are being made to provide support but the situation remains challenging. The transition from EU membership has not presented any specific concerns for workforce and this will continue to be monitored. The impact of budget allocations and the withdrawal of all Covid funding will also mean that HSCM are facing challenging recruitment decisions in 2023. The impact of budgetary decisions by the Council in relation to reducing staffing levels has reduced levels of support provided in some key areas Health and Social Care Moray (HSCM), such as ICT, HR, Legal and design. The lack of suitable housing for Health and Social Care staff has resulted in people not being able to take up posts in Moray. GP sustainability remains a national issue.	

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. Management competencies continue to be developed through Kings Fund training although this was suspended due to Covid19. A 2 day event was held on 16/17 May 2023, attended by the Senior Management Team as part of a Grampian wide event. Communications & Engagement Strategy was approved in November 2019 and continues. Council and NHS performance systems in operation with HSCM reporting being further developed and information relating to vacancies, turnover and staff absences is integral to this. Managers are highlighting any areas of concern and where appropriate this is identified in operational risk registers. Moray Council are carrying out a study of accommodation needs, including people working in the Health and Care sector.
Mitigating Actions:	System re-design and transformation. Organisational Development Plan and Workforce plan were updated and approved by MIJB in November 2019. The updated Workforce plan has been submitted to Scottish Government and comments were received by the HSCP in October 2022. These are currently being worked through. 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 have developed Multi-disciplinary teams in their areas and project officer support was 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.

	HSCM are working with Digital Health and Care Innovation Centre as partners on the Digital Health Improvement programme to research and design innovative ways to address the needs of citizens, versus the challenges of recruitment and skills available within Moray. Incentives have been secured to try and attract additional NHS dentists and dental practices to our area. The Scottish Dental Access Initiative now includes Moray, with grants of £50,000 and above available to allow dental practices to be established or extended– provided there is a seven-year commitment to providing NHS treatment. A recruitment and retention bonus is also being offered to eligible new dentists in Moray. GP sustainability Group and Primary Care Vison for the Future Groups in situ. Work is underway across the system to consider the implications of the Health and Care (Staffing) (Scotland) Act 2019.
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 continues to focus on leadership around emerging issues and resolving them, including staffing. The Heads of Service are co-ordinating and escalate to SMT where necessary. These meetings have been increased as service needs dictate.
Gaps in assurance:	Further work required to develop workforce plans to reflect strategic plan implementation programmes.
Current performance:	The iMatter survey results for 2023 were received by managers for review and action plans are now in place for implementation and review. Discussions are underway with HR in both Council and NHS to develop access to appropriate HR information at a summarised level to facilitate the necessary workforce planning and subsequent monitoring of plans. There continues to be a need for more streamlining in recruitment processes as the delay in approval to recruit to having a member of staff available is in excess of 8 weeks. There is also a lack of suitable applicants for various posts which is impacting on ability to appoint for some roles.
Comments:	Staffing issues are owned by the Systems Leadership Group who will work collaboratively across the system to seek opportunities to make jobs more attractive where it has proved difficult to recruit in the past. For some professions there is a potential risk that staff move from one position to a new position within HSCM will just move the vacancy to elsewhere in the system, so Senior Management Team are aware of this risk and taking it into

	account in considerations for vacancies. This needs to be considered when fixed term contracts and secondments are planned, consideration needs to be given to the whole of HSCM and not services in isolation. Many of our staff may have transferrable skills and experience. The continuing system issues and lack of available beds may mean operations cannot be scheduled to reduce the backlog and key staff may not have the necessary time in surgery to maintain essential skills. This in turn may add to the staff retention issues within certain specialties.

4		
Description of Risk: *Reputation:*	Inability to demonstrate effective governance and effective communication and engagement with stakeholders.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Performance framework to be further developed from a planning perspective to show the links through operational service delivery to strategic objectives. Feedback from community representatives and third sector organisations, across a variety of forums, highlighted issues. Clear focus and communications is required to ensure engagement and outcome needs are met.	
Rationale for Risk Appetite:	The Board is aware of the importance of good relationships with stakeholders. It recognises many of our ambitions require effective collaboration, co-production and partnership working with a range of stakeholders. The board also recognises that not all partners will be able to move at the same pace, all the time. We are aware of the need to protect and maintain good working relationships with all partners and stakeholders in order to deliver the outcomes set out in our strategic plan.	
Controls:	Governance Framework approved by IJB January 2021. A refresh of the Framework will be presented to Committee in November 2023. Communication and Engagement Strategy approved November 2019	

	Annual Governance statement produced as part of the Annual Accounts 2022/23 and submitted to External Audit. The unaudited accounts and governance statement for 2022/23 were presented to MIJB June 2023 and the audited accounts will return to committee in October 2023 for agreement. Annual Performance Report for 2022/23 was published in July 2023. Performance reporting mechanisms in place and being further developed through performance support team, home first group and system leadership team. Community engagement in place for key projects areas such as Forres, Keith and Lossiemouth with information being made available to stakeholders and the wider public via HSCM website. Participation of stakeholders in a variety of meetings such as Home First project, carer strategy, Strategic, Planning and Commissioning groups.
Mitigating Actions:	Schedule of Committee meetings and development days in place and implemented. New relationships are currently being established with Grant Thornton, the MIJB's newly appointed external auditor for 2022/23. The principles of the Equalities Impact Assessment are now embedded in the business as usual processes within Health and Social Care Moray. 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. A Public Engagement Communications Officer has now been appointed and started in post mid August 2023.
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 was impacted by the Covid 19. More use is being made of social media and Microsoft teams and other options and methods for engagement with staff are being used via NHSG such as videos on YouTube and one question surveys. Going forward there may be more opportunity for face to face meetings to take place again but it should be considered that this will not be beneficial for all.
Current performance:	Communication, Engagement & Participation Framework was reviewed approved by IJB November 2019. This will be reviewed by the new Public Engagement and Communication Officer.

	The Unaudited Accounts for 2022/23 were approved in March 2023, presented to MIJB and APR Committee in June 2023 and are now being audited, with the audited accounts to be presented in October 2023. The Annual Performance Report for 2022/23 was published in July 2023 after being presented to MIJB in June 2023.
Comments:	A communication cell is now established as part of the Local Resilience Partnership response with representation from Emergency Services, Councils, HSCP and NHSG. This forum provides assurance that messages to all stakeholders are consistent.

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:	As a result of the Covid 19 response, progress was made in a number of areas. SMOC information is updated, control room guidance updated and expanded, control centre protocols were implemented and remain in place and management teams have responded in an agile, responsive and collaborative way under very challenging conditions. Teams continue to do their best but there are areas where they still feeling overwhelmed and service delivery is challenging. With effect from March 2021 MIJB is defined as a Category 1 responder under the Civil Contingencies (Scotland) Act and there are additional requirements for preparedness that is being taken forward in partnership with NHSG and Moray Council emergency planners.	
Rationale for Risk Appetite:	The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act and the Category 1 status applied in March 2021, and work with partner organisations to meet these obligations.	
Controls:	Winter Preparedness Plans are being updated (but not tested as in previous years) with a delivery element sitting alongside the strategic plans. This is being rolled out via monthly meetings across all operational teams. Annual planning continues to dovetail with NHSG plans, and addressing the priorities outlined by Scottish Government. HSCM Civil Contingencies group meeting regularly to address priority subjects. NHS Grampian Resilience Standards Action Plan approved (3 year). Business Continuity Plans are now updated for most services and this review continues across HSCM. Knowledge of critical functions and ability to respond quickly and effectively has been in evidence during incidents such as Gas outages in Keith (January and February 2021) and Covid response, Storms (Arwen, Malik and Corrie) – debriefs carried out and learning identified. A Resilience Newsletter is now embedded as part of the winter planning and will inform staff of some personal resilience information together with resources for teams to plan. Regular updates to SMT and SLG regarding potential power outages across the country. Additional sessions were delivered to Primary Care Contractors to assist with their Business Continuity Planning around power outages. Regular system wide meetings to discuss potential Industrial Action implications and service planning.	

	A review of the Festive season arrangements was completed and as a result all services are now required to provide information about service cover available over holiday long weekends which enables a more collaborative and supportive approach.
Mitigating Actions:	Information from the updated BIA/BCP informed elements of the Winter Preparedness Plan Daily Response Group continues, this allows the status of services across the whole system to provide information and contact details to the Senior Manager on Call (SMOC) over the weekend. If any potential issues are highlighted the relevant Persons at Risk Data is compiled and if appropriate, shared with relevant personnel. NHSG have introduced system wide daily huddles to manage the flow and allocation of resources which require attendance from Dr Grays and HSCM. The format and regularity of these are under review. HSCM continues to monitor the local situation regarding impacts on staffing and is engaged with NHSG emergency planning arrangements and Council Response and Recovery management team to be ready to escalate response if required. Work was undertaken within NHSG, Aberdeenshire HSCP and Aberdeen City HSCP to look at Surge flows and establish a mechanism that will provide easy identification of "hot spots" across the whole system in Grampian, to facilitate a collaborative approach to addressing the issues through the use of a common Operational Pressure Escalation approach. This work could underpin surge responses in winter and at other times of pressure and having a standard approach across Grampian could aid communication and understanding. NHSG and the three Health and Social Care Partnerships completed a considerable amount of planning for potential Industrial Action from staff groups. This has allowed for testing of a range of communications and plans to be tested and will continue to develop. A System Networking Over Winter (SNOW) Event took place 28 September, the event was attended by health and social care partners across Grampian and also some Local Resilience Partner Agencies. A tabletop exercise event was carried out to exercise how the partners might work together.
Assurances:	Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny. HSCM Civil Contingencies group review specific risks and action plans to mitigate, developing plans and testing arrangements in partnership with NHSG and Council
Gaps in assurance:	Moray Integrated Joint Board (MIJB) was designated as a Category 1 responder under the Civil Contingencies Act 2004 from March 18th 2021. That designation imposed a number of statutory duties in terms of the Act and the associated

	Scottish Regulations[1]. MIJB has no dedicated, specialist in post and is reliant on the Corporate Manager covering this increasingly demanding role in addition to other duties without the necessary background, knowledge, skills and experience. This presents a potential organisational risk in terms of compliance, and our ability to provide assurance on discharging our civil contingency arrangements. This has been highlighted to the Chief Officer and IJB. The debriefs from the storms in 2021/22 have identified lessons learnt for Grampian Local Resilience Partnership and more locally for the response co-ordination within Moray. Actions were developed in collaboration with Moray Council's emergency planning officer to address the issues identified. The main issues related to developing wider awareness of roles and responsibilities, and improving general awareness of response structures and meeting protocols. This will be incorporated into training schedules going forward. It has also highlighted the need for a robust arrangement for out of hours contact and clarity of roles and responsibilities across the system which is being discussed at SMT. Option Appraisal discussions have commenced. 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. The 'Care for People' strategic document has been approved by HSCM SMT and CMT. It was presented to MIJB in September 2023. A draft operational response plan has been drawn up and has been circulated within the Senior Leadership Group for comment. An information session including the 'Care for People' element was delivered on 2 May 2023, to senior managers who carry out the role of SMoC, this included input from Moray Council Emergency Planning Officer and NHS Grampian. An additional session was delivered 26 September, with a specific focus on the draft Care for People framework. A further tabletop exercise is planned for November 2023. Table top style exercises were carried out with some services who had submitted their finalised Business Continuity plans in February 2023. Development of a HSCM Persons at Risk Database (PARD) continues and all partners are now involved, looking to improve the quality of the data held. HSCM is also working with Aberdeen City, Aberdeenshire and NHS Grampian at a system wide approach. The system that currently records the data used for PARD is to be replaced, this function is integral to responding to incidents.
Current performance:	The Senior Management Team have undertaken 'Strategic Leadership in a Crisis' training since 2020 and continue to do so as the programme is delivered.

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

	Many services have business continuity arrangements and some are overdue for an update. Work has progressed in identification of a critical functions list for agreement by System Leadership Group that will inform planning arrangements going forward. There will need to be changes made to business continuity plans following the implementation of additional ICT resources in services which have provided a greater deal of resilience for some services and functions – albeit reliant on electricity supply. A schedule of review and exercising of business impact assessments and plans has been scheduled for this year across services. All services have been requested to prioritise their Business Continuity planning with a particular lens on power outages. Annual report on progress against NHS resilience standards was presented to the APR committee on 30 March 2023. Report on the implications and risks of the designation as a Category 1 responder was presented to MIJB 25 November 2021. Work is currently underway to plan for possible National Power Outages across the UK. This is being co-ordinated across Grampian to ensure all Partners are involved. Information/planning sessions were also delivered via HSCM to our Primary Care partners. They were invited to share emergency plans with the partnership.
Comments:	The requirements of a Category 1 Responder continue to increase in demand placing increased pressures across already overstretched services and managers. The Manchester Arena Inquiry has resulted in a focus on Category 1 responders responsibilities, together with an increase of additional policies and procedures to be written and implemented with no additional resource. MIJB does not have a subject matter expert leading on these topics. NHS Grampian identified that 54 buildings/areas within their estate may potentially have Reinforced Autoclaved Aerated Concrete (RAAC) within the structure. This is a lightweight form of concrete used mainly in roof, floor and wall construction in the UK from mid 1950s to mid 1990s and has been found to be at risk of destabilising. Surveys have not identified RAAC in any of the buildings within Moray. However, Primary Care Contractors, which is a hosted service within HSCM, may occupy buildings within Grampian that are affected. Work is ongoing to identify this. Only NHSG buildings have been surveyed to date.

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	**NO CHANGE**
Rationale for Risk Rating:	~~Considered medium risk due to the impact of Covid-19 and resultant efforts required to remobilise services and/or the increase in workloads stretching a workforce that has been under sustained pressure for a considerable time.~~ The ongoing ~~impact of the Covid 19 pandemic~~ recovery from the Covid-19 pandemic is stretching resources to deliver care in the community across all providers (internal and external) so there is a potential ~~increased~~ risk of expected standards not being achieved despite the best efforts of all concerned.	
Rationale for Risk Appetite:	The Board, staff and providers across Moray are all committed to ensuring high standards of clinical care & governance through operational policies. Innovation and new ways of working may mean traditional regulations do not exist and require to be developed, no longer apply, or are contradictory. We will only take regulatory risks knowingly, following consultation with the relevant regulatory body and where we have clear risk mitigation in place.	
Controls:	Clinical and Care Governance (CCG) Committee established and future reporting requirements identified Clinical Risk Management and Practice Governance group has oversight of their respective professional standards and links into Clinical and Care Governance Group, which escalates to CCG Committee as necessary. High and Very High operational risks are reviewed by NHS Grampian Clinical Risk Management and System Leadership Group monthly and a review of all risks will be undertaken as part of the risk management framework. Workshops took place in January and February 2023, 'A conversation about Clinical Governance'. A session on Risks and Risk Management was delivered to a wide ranging group of managers in HSCM in September 2023 by NHSG Risk Advisor. A trial has been started to transfer all risks onto Datix Risk Register platform to give oversight of all operational risk registers. This will be reviewed before rolling out across all services. Complaints, compliments and enquiry procedures are in place and are being reviewed and monitored. Clinical incidents and risks are being reviewed on a fortnightly 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. Care Home Collaborative Support Group meets to oversee and manage risks in care homes. Children and Adult Protection services are being delivered and reported to their respective committee on a regular basis.
Mitigating Actions:	This risk is discussed regularly by the three North East Chief Officers. ~~Additional resource has been allocated to support the analysis of information for presentation to CCG committee~~ All High and Very High risks are now brought before the Senior Leadership Group in Moray. Process for sign off and monitoring actions arising from Internal and External audits has been agreed
Assurances:	Audit, Performance and Risk and Clinical and Care Governance Sub-Committees oversight and scrutiny. Governance Framework in place and operational. This is currently being refreshed and will be presented to the CCGG Committee in November 2023.
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.
Current performance:	External inspection reports are reviewed and actions arising are allocated to officers for taking forward. Two Days of Care Survey took place across Moray on 25th and 26th January, 2023 respectively. These were led by the Clinical Service Leads. The findings of these events were compiled and outcomes are assessed by the relevant service leads and SMT. A further round of audits on Social Care will now be completed and a full report will be considered if necessary, dependant on outcomes. It is also planned to schedule this as a possible annual event. A summary of inspections is included in the Annual Performance report.
Comments:	No major concerns have been identified for HSCM services in any audits or inspections during 2021/22. An inspection of Childrens Services commenced in August 2023, this will take place over a number of months.

7	
Description of Risk:	Inability to achieve progress in relation to national Health and Wellbeing Outcomes.

Operational Continuity and Performance:	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 and delayed discharges place additional cost and capacity burdens on the service. The level of delayed discharges has remained challenging, reflecting the sustained pressure in the system following the Covid -19 pandemic impact and the lack of availability of care in the community. There are sustained focussed and collective efforts by all those working in the pathway. However this is a complex area and will require continued effort to realise reductions and maintain them.	
Rationale for Risk Appetite:	The Board is cautious but open about risks that could affect outcomes that are priorities for people in Moray. There is a slightly higher appetite to risks that may mean nationally set outcomes – that by design are not given a high priority in Moray - are not met. There is new focus on addressing positive risk taking to ensure the most appropriate and timely measure of care for the population of Moray, this is being supported through various work streams across the system. 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. 2022 to 2032 “Partners in Care” Strategic Plan was approved and the delivery plan is now complete and was presented to MIJB in September 2023. Performance is regularly reported to MIJB. Revised Scorecard being developed to align to the new strategic priorities. Best practice elements from each body brought together to mitigate risks to MIJB’s objectives and outcomes. Chief Officer and SMT managing workload pressures as part of budget process. A daily Huddle and write up circulates the picture on performance across community and acute services for the Portfolio and service managers have a shared understanding of the pressures in the system and mitigations taking place. Work continues on refinement of G-OPES (Grampian Operating Pressures and Escalation System) led by NHSG but being developed locally to identify the triggers and resultant actions required in services to respond to pressure points.	

Mitigating Actions:	Service managers monitor performance regularly with their teams and escalate any issues to the System Leadership Group (SLG) for further discussion to provide wider support, developing shared ownership and a greater understanding across the whole system. Key operational performance data is collated and circulated daily to all managers. A Daily dashboard is held on illuminate for managers to access to ensure any potential issues are identified quickly so action can be taken. This dashboard is being reviewed and will be further developed with the intention of further dashboards to provide a whole system overview. This has been discussed at SLG and agreed. Performance information is presented to the Performance sub group of Practice Governance Group to inform Social Care managers of the trends in service demands so that resources can be allocated appropriately.
Assurances:	Audit, Performance and Risk Committee oversight. Operationally managed by service managers, summary reports to Practice Governance and clinical and care governance group and to System Leadership Group. Strategic direction provided by Senior Management Team. HSCM Response Group continues to meet and reviews the key performance information and actions that are required to deliver the priority services.
Gaps in assurance:	Development work in performance to establish clear links to describe the changes proposed by actions identified in the Strategic Plan has recommenced but is at an early stage. This will be progressed as the revised outcomes are determined and associated KPI are identified. Progress will be reported to future Board meetings. Review of systems and processes will commence across HSCM to ensure they are fit for purpose and ensure that there are no indirect consequences of structure changes resulting in any gaps in assurance processes.
Current performance:	Services continue to recover from the pandemic and discover a new 'battle rhythm', taking into account all new learning and experience from the pandemic. There are likely to be changes to ways of working and this may also have impact on the performance information required. The Unmet need report continues to show improvement in a number of Performance Indicators, with a number of them now showing continued improvement over the longer-term.
Comments:	Locality profile information has been provided to Locality Steering Group/Locality Manager to inform potential priorities for consideration in Localities and work will be taken forward regarding development of performance monitoring and reporting of key performance indicators in relation to Localities once it has been determined what the intended outcomes are. Locality plans are now scheduled to report to MIJB on a quarterly basis. The Portfolio Flow Group has produced an action plan for implementation and progress is being made.

	Practice Governance have reviewed their operational performance requirements and have a comprehensive data set used to inform operational priorities. The Home First priorities are being taken forward and updates are reported to this committee or MIJB on a regular basis. This work is being undertaken across the Moray Portfolio to improve wider system flow. Progress in this area has been hampered due to the increased demand for urgent or critical services requiring staff resource to be prioritised to frontline service delivery. The Council has procured new modules for their performance reporting system Pentana and HSCM performance team have been developing its use for reporting. HSCM are working in partnership with the Rural Centre of Excellence on transformation projects, the foundation of planning is addressing how we can improve the delivery of health and wellbeing outcomes and also the strategic aims of 'Partners in Care'.

8		
Description of Risk: *Transformation*	Inability to progress with delivery of Strategic Objectives and Transformation projects.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	There are many issues that will impact on the ability to progress to deliver Strategic Objectives. The Strategic Planning & Commissioning group has been refreshed and re-launched and key work is being progressed. There was an initial meeting held on 22 September 2021 to consider terms of reference and the proposed structure for oversight, prioritisation and assurance in relation to key developments, their fit with IJB strategy and enabling elements. ~~The interim appointment of the Strategic and Planning Lead provides capacity to take this forward and to align the priorities arising nationally, Grampian-wide and locally.~~ The remobilisation plan for HSCM services that were suspended or reduced is progressing with Providers services and social work implementing the IJB decision to return to delivery of both substantial and critical eligibility criteria. Work has progressed risk assessments are completed and assessments have been or are in the process of being reviewed to ensure equality. The impact of Covid 19 on the population of Moray is still not fully realised. It is therefore not possible to predict the extent of the impact on the ability to progress with delivery of Strategic Objectives. There are some aspects that have progressed very well such as introduction of Near Me consultations but there are others that are more difficult to progress. There is concern that due to the workloads and challenges over the last year that teams are weary and/or do not have capacity at this moment in time, to progress with delivery of development plans at this moment in time. In addition the pandemic is still present in the community so services are still responding to the impacts it has for the population of Moray. Managers are working with teams to establish “readiness” and their capacity and sense of wellbeing and the collated output will inform plans going forward. One key aspect to facilitate transformation is the need for progress in relation to ICT infrastructure, data sharing and data security across the whole system. Work was undertaken by NHS Grampian and partners to address the needs for ICT kit and information during the response to Covid.	

Rationale for Risk Appetite:	The Board has a high appetite for risks associated with delivery of transformational redesign. The following should be considered when accepting these risks: • We understand and can mitigate other risk types that may arise, e.g. safety or financial within appetite • Service users are consulted and informed of changes in an open & transparent way • We will monitor the outcome and change course if necessary
Controls:	It is recognised that there will be significant changes taking place in Social Work practice with the implementation of the Self Directed Support standards and the move to outcomes based services, so governance arrangements are being set up to facilitate the same type of oversight and communication that is in place for the Home First programme. The Strategic Delivery Plan has been developed by the Heads of Service and Interim Strategic Planning Lead.
Mitigating Actions:	Integrated Infrastructure Group previously established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters which is an area that will be taken forward alongside the Moray Growth Deal projects. The Moray Transformation Board has recently restarted and will link to all relevant groups.
Assurances:	Strict ICT and data sharing policies and protocols in place with NHS Grampian and Moray Council. A Moray Portfolio Infrastructure Programme Board has been established to support the operational delivery of the aims and objectives set e.g. Analogue to Digital changeover, Buildings and Assets oversight and Smarter Working will support this agenda.
Gaps in assurance:	Protocol for access to systems by employees of partner bodies are in place. Information Management arrangements to be developed and endorsed by MIJB. Process of identification of issue and submission to data sharing group requires to be reinforced to ensure matters are progressed. The strict information sharing protocols can cause issues when trying to work across system in an open and transparent way. Smarter Working programmes are being progressed in partnership with Council and NHSG. The Strategy and Planning Lead Vacancy will likely cause disruption to the transformation and implementation planning required in the delivery of the Strategic Plan
Current performance:	Training to promote records management, data protection and related issues for staff working across and between partners using the learning and development resources of NHS Grampian and Moray Council.
Comments:	Where national systems are involved it may not be possible to identify a solution however the issues will be able to be raised at the appropriate level via the Grampian Data Sharing Group where all three partnerships are represented.

9		
Description of Risk: *Infrastructure*	Requirements for support services are not prioritised by NHS Grampian and Moray Council.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Changes to processes and necessary stakeholder buy-in still bedding in. Moray Council is undertaking a Property review of office and depot accommodation and the potential impact for HSCM services requires consideration. The output was anticipated in October 2019 however due to changes with roles and responsibilities within the Council however the paper has been out for consultation. NHSG have advised that staff should continue to work from home at present whilst policies and protocols are developed. Moray Council have a dedicated MC officer leading on a hybrid working plan with input from HSCM on their requirements. It is anticipated that this will conclude December 2023. 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.	
Rationale for Risk Appetite:	Low tolerance in relation to not meeting requirements.	
Controls:	Chief Officer has regular meetings with partners. Computer Use Policies and HR policies in place for NHS and Moray Council and staff. PSN accreditation secured by Moray Council Infrastructure Programme Board was established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT. Process for submission of projects to the infrastructure board approved and implemented to ensure appropriate oversight of all projects underway in HSCM. The Board has only recently restarted, so in the interim, project requests are being processed via Senior Management Team. The interim Strategy and Planning Lead will support the Infrastructure Programme Board for Moray portfolio.	
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
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 have been recently 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. Due to staff changes this work will now be incorporated into other roles. This will likely mean that this work will complete with other priorities of already busy roles. Legal services have reduced capacity to provide support due to budget cuts and vacancies so any requests are taking longer. Internal Audit Services have indicated that their capacity to complete all work required by MIJB may be an issue. This is being discussed with Moray Council. Recruitment for vacancies takes considerable time due to various factors and is presenting a strain on services to maintain normal service whilst covering vacancies. There have been several posts that have had to go out to advert more than once extending the time other staff are covering gaps.
Current performance:	No update.
Comments:	Existing projects will be reviewed as part of the development of the transformation plans for the Strategic Plan to ensure resources are being dedicated appropriately and aligned to the emerging Strategic priorities. Our requirements for support will be communicated via appropriate channels The delegation of Childrens and Families and Justice Services should continue to be supported by the corporate services within Moray Council.

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 30 NOVEMBER 2023**

SUBJECT: **HEALTH AND SOCIAL CARE MORAY (HSCM) CLINICAL AND CARE GOVERNANCE GROUP UPDATE**

BY: **CHIEF NURSE, MORAY**

1. REASON FOR REPORT

1.1 To inform the Committee of progress in refreshing the Clinical and Care Governance Framework in Health and Social Care Moray.

2. RECOMMENDATION

2.1 It is recommended that the Committee:-

i) consider and note the progress made in re-establishing the Clinical and Care Governance Group (CCGG);

ii) note that the CCGG and Practice Governance Board (PGB) will provide assurance reporting from CCGG to this Committee on a quarterly basis; and

iii) note that CCGG and PGB will escalate any issues via CCGG to Committee, including recently delegated services of Childrens and Families and Justice Services.

3. BACKGROUND

3.1 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 (CRM) Group as described in a report to this Committee on 30 May 2019 (para 7 of the minute refers).

3.3 As reported to this Committee on 29 October 2020 (para 5 of the minute refers) Social Care representatives attend the Clinical Governance Group so the group was renamed HSCM CCGG.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Terms of Reference (**APPENDIX A)** has been refreshed, incorporating the PGB and recently delegated services.

4.2 The reporting structure (referred to as **Appendix 2** in **Appendix A**) has been refreshed and approved by the CCGG. The tight control of the number of papers being presented will allow for greater discussion amongst group attendees.

4.3 A new reporting template (referred to as **Appendix 5** within **Appendix A**) will ensure that services are clear what information is being provided for either assurance or escalation. This will improve the quality and decision making of the reporting to this Committee.

4.4 The group will be chaired by one of three Professional Leads; Fiona Robertson, Chief Nurse (Interim) Moray, Tracy Stephen, Head of Service/Chief Social Work Officer and Audrey Steele-Chalmers, Lead Allied Health Professional Moray.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"
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 Management Team and to this 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, scrutinise 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 CRM group reviews all events logged on Datix, ensuring risk is identified and managed.

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

(f) Property
None directly arising from this report.

(g) Equalities/Socio Economic Impact
There is no requirement for an equality impact assessment because there is no change to policy required as a result of this report.

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

(i) Directions
None directly arising from this report.

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

- HSCM Clinical and Care Governance Group members and Chairs
- Sonya Duncan, Corporate Manager
- Caroline O'Connor, Committee Services Officer, Moray Council
- Isla Whyte, Interim Support Manager
- Liz Tait, Lead for Clinical Governance, HSCM

6. CONCLUSION

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

6.2 There will be continued review and development of this framework as the Portfolio vision across Grampian is realised.

Author of Report: Sonya Duncan, Corporate Manager, HSCM,
Isla Whyte, Interim Support Manager
Background Papers: with author
Ref:

APPENDIX A

Health and Social Care Moray Clinical and Care Governance Group (CCGG) Role and Remit

Date of Issue:	**Date of Review:**
October 2023	October 2025

UNCONTROLLED WHEN PRINTED

Version 1.6

Introduction:
"Clinical governance is the system through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services and safeguarding high standards of care and services".
Healthcare Improvement Scotland (2005)

"Care governance is a robust system for assuring high standards in the delivery of safe, personalised and effective health and social care services".
Social Work Scotland – Governance for quality social care in Scotland

Guidance on the key elements and principles to be reflected in local clinical and care governance of integrated health and social care arrangements can be found here:

https://www.gov.scot/publications/clinical-care-governance-framework/

The Key Principles and Process Steps from this guidance are detailed below

Five Key Principles of Clinical and Care Governance:

1. Clearly defined governance functions and roles are performed effectively.

2. Values of openness and accountability are promoted and demonstrated through actions.

3. Informed and transparent decisions are taken to ensure continuous quality improvement.

4. Staff are supported and developed.

5. All actions are focused on the provision of high quality, safe, effective and person-centered services.

Five Process Steps to Support Clinical and Care Governance:

1. Information on the safety and quality of care is received

2. Information is scrutinised to identify areas for action

3. Actions arising from scrutiny and review of information are documented

4. The impact of actions is monitored, measured and reported

5. Information on impact is reported against agreed priorities

Aim:

The Health and Social Care Moray (HSCM) Clinical and Care Governance Group is responsible for ensuring that systems and processes are in place across all service areas within HSCM to support clinical and care governance; providing assurance to the HSCM Senior Management Team (SMT) and Moray Integration Joint Board (MIJB) Clinical and Care Governance Committee, that these systems are in place and performing effectively. To ensure the safe and effective delivery of care and maintenance of service delivery.

Moray Council, NHS Grampian and the Moray Integrated Joint Board (MIJB) are accountable for ensuring appropriate clinical and care governance arrangements for services provided in pursuance of integration functions in terms of the Public Bodies (Joint Working) (Scotland) Act 2014. As such there is a requirement to consider existing processes in place to assure clinical and care governance, and develop an integrated process and structure capable of a whole system approach.

Objectives:

- To provide support and assurance to MIJB Clinical and Care Governance Committee at an operational level and inform decision making.
- To support and assist HSCM in achieving its clinical and care governance responsibilities.
- To provide a coordinated and integrated approach to clinical and care governance across all services.
- To inform, support and advise HSCM staff on clinical and care governance issues, ensuring and enabling best practice and high quality safe patient care.
- To encourage ownership and collaboration with staff informing the working of the group, highlighting issues of concern and good practice.
- To reflect single system working through collaboration with all partners.
- To Identify and escalate any risks relating to clinical and care service delivery.

Role of Chair:

- Setting the agenda to promote effective decision making and constructive discussion.
- Leading the group to agree items for escalation to the MIJB Clinical and Care Governance Committee and HSCM SMT.

Purpose of the Group:

The role of the HSCM Clinical and Care Governance Group (CCGG) is to oversee and provide a coordinated approach to clinical and care governance issues within HSCM.

The CCGG has a responsibility and accountability to ensure that there are robust mechanisms for reporting clinical and care governance issues and for providing onward communication to the MIJB Clinical and Care Governance Committee and HSCM SMT

To provide exception reports to the MIJB Clinical and Care Governance Committee on a quarterly basis.

The MIJB Clinical and Care Governance Committee will produce an annual report for submission to the NHS Grampian Clinical Governance Committee providing Board activity which will evidence robustness in regards to procedures.

Membership:

Membership of the CCGG is representative of HSCM, which incorporates a diverse range of services. Representatives of each discipline are invited into the group allowing them a platform from which to share their knowledge, experience and opinions and escalation of risks related to clinical and care governance in relation to quality and service delivery. As part of their role as a member of the CCGG, members are expected to feedback on work of the group to their individual Profession/Service.

The group will extend invitations to other groups or representatives as required to address set agenda items or to seek further insight and assurance on a set issue.

Membership of Health and Social Care Moray Clinical and Care Governance Group includes:

Membership*

Health and Social Care Moray Operational Representation

- Chief Nurse, Moray (Joint Chair)
- Chief Social Work Officer (CSWO) (Joint Chair)
- Allied Health Professional (AHP) - Professional Lead (Joint Chair)
- HSCM Head of Service
- HSCM GP Clinical Lead
- HSCM Children and Families Health Services Lead
- Operational Lead Nurse, Moray
- Locality Manager (by rotation)
- HSCM Corporate Manager
- Social Care Service Manager (by rotation) representing Adult Services Practice Governance Board
- Social Care Service Manager (by rotation) representing Childrens and Families and Justice Practice Governance Board
- PCCT Service Manager

In Attendance

Specialist/ Professional Advisors*

- Clinical Governance Coordinator
- Lead Pharmacist
- Primary Care Development Manager
- Quality Improvement Leads
- HSCM AHP Representative
- HSCM Dental Clinical Lead or deputy
- HSCM Primary Care Out of Hours Lead Nurse (GMED)
- Moray Practice Managers Group Representative

- HSCM Integrated Service Manager, Mental Health
- Social Care Consultant Practitioners/Service Manager (as required) (by rotation)
- Staff side representative (tbc)

Members are expected to have a deputy, to ensure attendance is maintained from all representative areas. All papers being tabled will require a representative to present the paper.

**Membership may be extended as appropriate.*

Quorate: The group will be quorate with the following representation;

- Chair
- Three members of HSCM Operational Representation
- Three Specialist/ Professional Advisors or their deputies

Frequency of Meetings:
Meetings will be held monthly.

Running of Meeting:
The meeting will be structured with standing items: as follows;

- Welcome and Apologies
- Minute of Previous Meeting
- Action Tracker
- Clinical Risk Management (CRM) Update
- Items from Practice Governance Board

And

- Service Exception Reports

(The expectation would be that each service would present twice per year, with no upper limit of reports). A rolling schedule of reports presented will be collated and reviewed quarterly for assurance. Any services found not to be represented will be contacted by the Chair. Services can present as often as required if there are areas of concern or escalation required.

- Quality Reports - these will presented by work stream leads
- Quarterly Reports from Groups e.g. Falls Group/HAI/Food Fluid & Nutrition

Agenda items and papers are invited from each of the above representatives and are submitted to the CCGG Administrator for distribution. The agenda is set two weeks prior to the meeting by the Chair (**Appendix 4**). The agenda and papers are sent out to the group one week in advance in preparation for the meeting.

Service Exception Reports are to be submitted using the template at **Appendix 5**.

(Definition of Exception: A statement disclosing the dissimilarity between actual and expected occurrences. Exception reporting allows issues to be escalated so that they can be resolved / monitored).

The group maintains the right to hold closed sessions in instances where there may be a risk of breaching patient confidentiality, in accordance with the Data Protection Act or where clinically sensitive issues are to be discussed. **(Appendix 1)**

Reporting Structure:
Issues raised within the CCGG are recorded within a formal exception report prepared for MIJB Clinical and Care Governance Committee.

Adult Social Care services manage their governance issues and shared learning via the Practice Governance Board (PGB). A senior manager from this group will attend CCGG to update and represent any issues raised via PGB. If required, they may invite other members of PGB to present at CCGG (as agreed by the Chair).

This process will be replicated by Childrens and Families and Justice Services, with a representative from their PGB also attending CCGG. Future plans anticipate that the PGBs will merge into one group, but the reporting to CCGG and MIJB Clinical and Care Governance Committee will remain the same.

The Framework outlining CCGG reporting structure can be viewed in **Appendix 2.**

- Overall accountability is held by the Chief Officer who delegates responsibility to the Chairs of the CCGG, for this meeting purposes only.

Accountability is escalated to the MIJB Clinical and Care Governance Committee.

The Framework outlining the wider system reporting structure can be viewed in **Appendix 3.**

Resources and Budget:
Business of the meeting is recorded in formal minutes, taken by the secretary to the HSCM CCGG.

Author: Clinical and Care Governance Group

Appendix 1:

Health and Social Care Moray Clinical and Care Governance Group – Closed Session Agreement.

The closed session will be attended by a core group of individuals. Those requested to attend will be contacted prior to the meeting, with details of an agreed agenda.

The core group of individuals attending these sessions may include:

- Head of Service
- Clinical Lead
- Chief Nurse / Nurse Manager
- AHP Lead

Others may be requested to attend, depending on the nature of the issue.

Closed sessions will be held in instances where patient / staff confidentiality is at risk of being breached or where highly sensitive issues are being discussed. These instances may include:

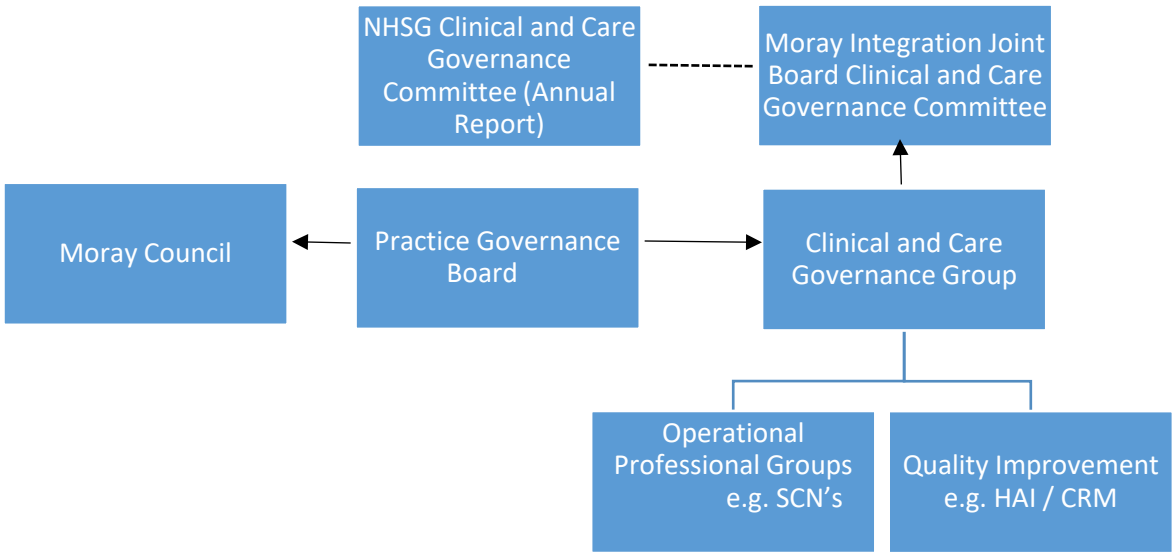
- The review and monitoring of information pertaining to significant event analysis / critical incident review / near miss or untoward incident and is patient or staff sensitive which may be at risk of breaching the Data Protection Act.

- To protect confidentiality in relation to highly sensitive or potentially controversial issues.

- To monitor and review the outcome(s) of investigations into serious service failure or issues relating to underperformance.

Appendix 2

Health and Social Care Moray Clinical and Care Governance Reporting Structure



Operational Professional Groups:
Nursing
Health Visiting
District Nursing
Allied Health Professionals
Primary Care: Pharmacy, Optometry, Dental, General Practitioners
Practice Managers Group Representative
Public Health

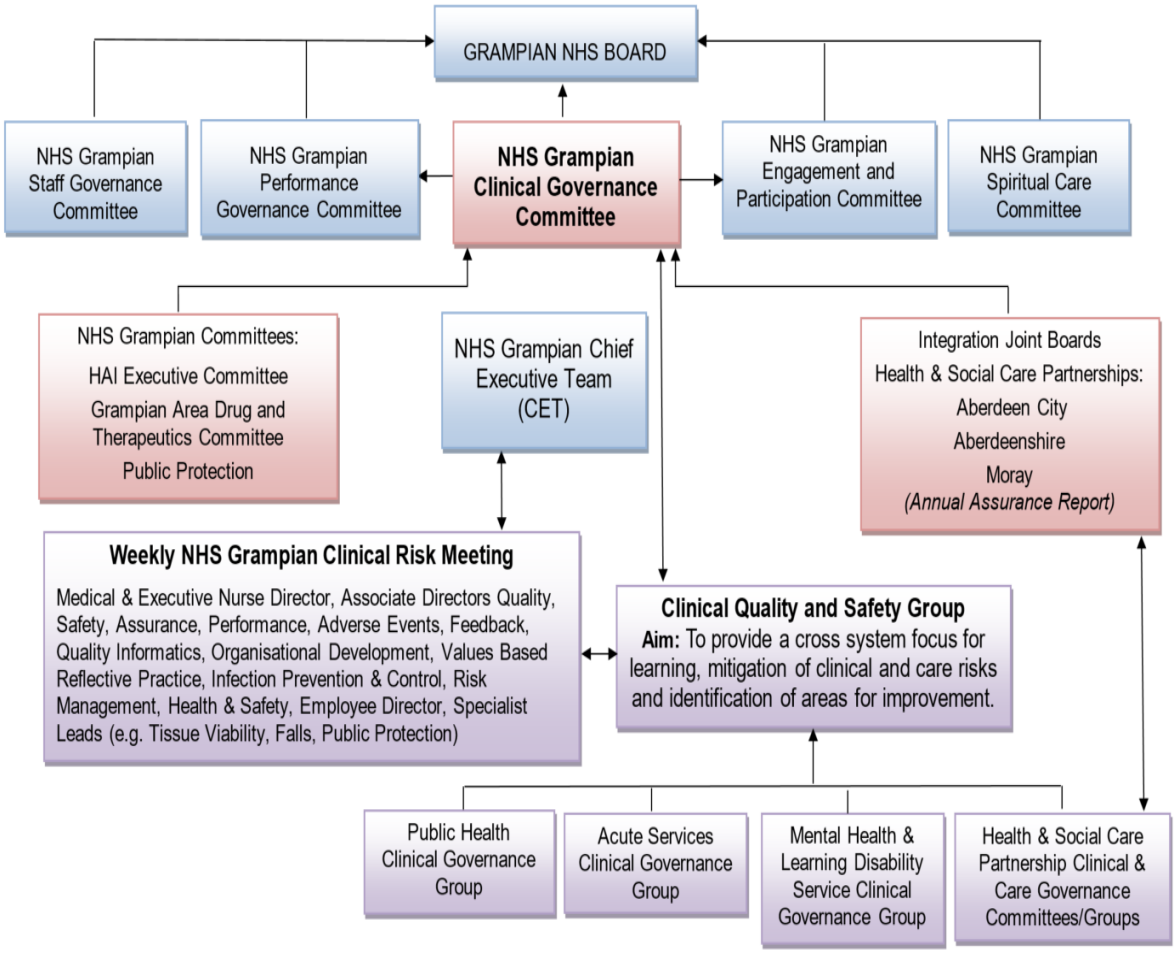
Hosted Services:
GMED

Quality Improvement Groups:
Food, Fluid & Nutrition
Hospital Acquired Infection Group (HAI)
Infection, Prevention and Control (IPC)
Clinical Risk Management (CRM)

APPENDIX 3

Wider System Reporting Framework

NHS



Appendix 4

Health and Social Care Moray
Clinical & Care Governance Group
To be held on
Thursday ** 1530 - 1700**
Meeting via MS TEAMS

AGENDA

Item		Lead	Ref
1.	**Welcome & Apologies**	Chair	#
2.	**Minutes of previous meeting**	ALL	*
3.	**Matters Arising**	Chair	#
4.	**Action Tracker**	Chair	*
5.	**Clinical Risk Management (CRM)** update presented by Chair		#
6.	Items from Practice Governance Group (individual papers to be submitted under Item 7).	CSWO or Deputy	*
7.	**Reports from: (Pref. max 3 papers)** a) b) c)		*
8.	**Other reports/ updates** a) External Reports (for information only) b) e.g. Inspire Quality (quality improvement & assurance newsletter)		* *
9.	**Items agreed for escalation to Clinical & Care Governance Committee (Led by Chair – full report or inclusion in Exception Report)** **a)**	ALL	
10.	**AOCB**	ALL	#
11.	**Date of Next meeting**		

Appendix 5

Health and Social Care Moray **Clinical and Care Governance Group** **(CCGG)Exception Reporting Template**		
Service:	Date of Meeting:	
All reports should have followed own internal governance before being presented at CCGG (this is the responsibility of the author)		
All sections need not be annotated if not applicable. *Exception reporting should identify:* • *situations/outcomes which may affect patients, staff or if services are at risk/unsafe* • *weaknesses/risks in current service delivery or evidence/trends that suggest there may be increased risk to patients or staff.*		
1. Area of concern *e.g. patient care is at risk of being compromised/risk to staff wellbeing/financial risk/staff recruitment/retention issues*		
2. Progress against Action Plans *e.g. Audit, Inspections*		
3. Duty of Candour event (*please give brief outline of event and actions to date/planned actions – do not give identifiable personal information unless a closed session has been requested*)		
4. Complaints/Large Scale Inquiries ***(identify any shared learning from any level, including action taken as a result of a complaint)***		
5. Adverse Events – ***shared learning***		
6. Audits/Inspections/Peer Reviews/Quality Improvement Initiatives		
7. Areas of Good Practice/Shared Learning		

8. Other items of Concern	
Report Compiled by:	
Name:	Designation:

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 30 NOVEMBER 2023**

SUBJECT: **COMPLAINTS REPORT FOR QUARTER 2, 2023/2024**

BY: **CLINICAL AND CARE GOVERNANCE GROUP CO-CHAIRS**

1. REASON FOR REPORT

1.1 To inform the Committee of complaints reported and closed during Quarter 2 (1 July 2023 – 30 September 2023).

2. RECOMMENDATION

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

3. BACKGROUND

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

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

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

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

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

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

4. KEY MATTERS RELEVANT TO RECOMMENDATION

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

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

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

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

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

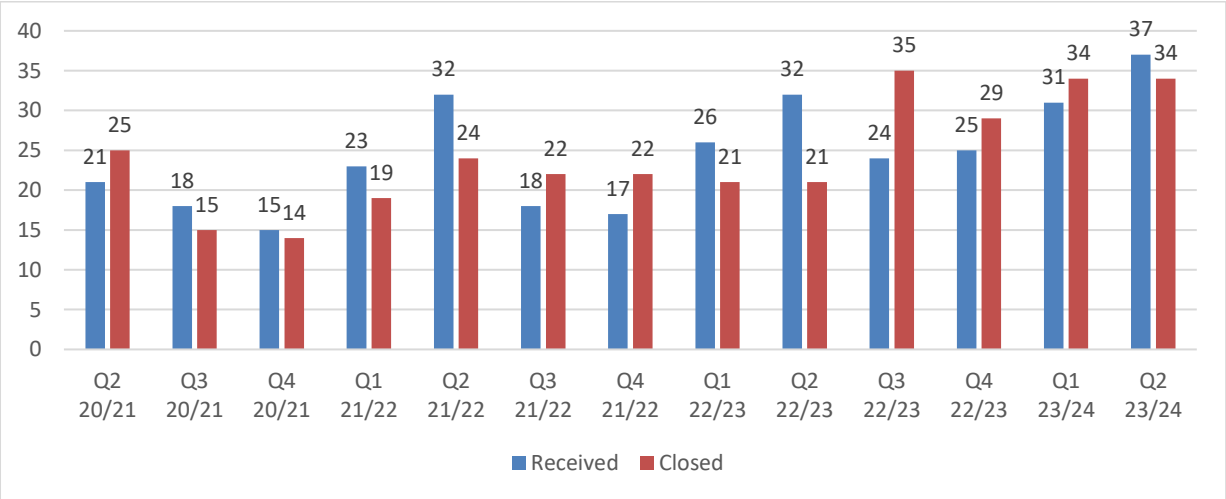
4.5 Figures reported do not include complaints raised regarding the vaccination appointments or processes as these are being dealt with through a dedicated team covering the Grampian area. Any complaints or comments regarding the Fiona Elcock Vaccination Centre in Elgin will be included in reported figures.

4.6 Following ministerial approval, Children and Families and Justice Social Work Services were formally delegated by the LA to MIJB on 16 March 2023. All complaints and enquiries received regarding these services and recorded on Lagan are captured in **Appendix 1** and the figures below.

4.7 Overall, a total of 37 complaints were received during Quarter 2.

	Total Rec'd Q3 22/23	Total Closed Q3 22/23	Total Rec'd Q4 22/23	Total Closed Q4 22/23	Total Rec'd Q1 23/24	Total Closed Q1 23/24	**Total Rec'd Q2 23/24**	**Total Closed Q2 23/24**
LA	4	6	9	8	17	21	**16**	**9**
NHS	20	30	16	21	14	13	**21**	**25**
	24	**35**	**25**	**29**	**31**	**34**	**37**	**34**

4.8 The table below sets out HSCM complaints received and closed by Quarter. Children and Families and Justice Social Work services figures are included from Q1 2023/24 onwards:



4.9 There were 18 MP/MSP enquiries received regarding council services, under HSCM (including Children and Families and Criminal Justice), and recorded on the Council system, Lagan. These were allocated as follows:

Service	Number of Enquiries
Care at Home	1
Community Care Finance	2
Fostering and Adoption and Supported Lodgings	3
Occupational Therapy	1

Access Team	6
Children and Families Area Teams	4
Moray West	1

4.10 Four of these enquiries were closed as they were out of jurisdiction.

4.11 Enquiries have been received from MPs/MSPs and Councillors direct to managers in HSCM. At this stage it is not possible to accurately report on numbers received due to these enquiries not all being logged centrally. A short life working group is now established to review current processes and to create a mechanism to record these enquiries on the Datix system. This will give oversight of all enquiries for the senior management team and enable accurate reporting to this Committee. It is anticipated the next report to Committee will include these figures.

4.12 Any complaints received from MPs/MSPs on behalf of constituents regarding health services, under HSCM, are recorded on Datix and captured in the data provided at Appendix 1.

4.13 One enquiry and 2 concerns were received during Quarter 2 and recorded on Datix.

4.14 Work is being done to support members of the public to complain / provide feedback on their experiences. HSCM's "How to Complain" Leaflet is currently being revised and once complete, copies will be sent to teams. The HSCM webpage will be undergoing a review and the Feedback and Complaints page will be more prominent. Other ideas are being explored, for example; a section in a future edition of Moray Health & Care News (a newsletter delivered throughout Moray) and Freepost feedback forms for services to have available.

4.15 A webinar, led by the Executive Director & Head of Care Opinion Scotland, last month gave an opportunity for the HSCM Corporate Manager and colleagues to hear more about Care Opinion and its uses for Health & Social Care Partnerships. Further information is being sought on the various subscriptions available.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"

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

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

(b) Policy and Legal

CCG 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 CCG Committee. There are platforms within Health and Social Care to discuss and share good practice, learning and challenges.

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

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

(f) Property
None directly arising from this report.

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

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

(i) Directions
None directly arising from this report.

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

- Corporate Manager
- Caroline O'Connor, Committee Services Officer, Moray Council
- CCG Group

6. CONCLUSION

6.1. This report provides a summary of HSCM complaints received and closed during Quarter 2 (1 July – 30 September 2023). The governance and monitoring of complaints forms part of core business for teams and services and the provision of a good quality, effective and safe service is a key priority for all.

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

APPENDIX 1

Complaints Data (by closed complaints)

Quarter 2 (01/07/23 – 30/09/2023)

Learning from complaints

Teams and services actively review all forms of feedback to see where improvements can be made and share any learning.

The tables 1, 2, 3, 4, 5, 6 and graph 1 below set out the outcomes of closed complaints, what service received the complaint and any actions taken /learning.

Table 1

Complaints Information Extracted from Datix – 25 complaints were **closed** during Quarter 2, 2023/24.

Actions Taken/Outcome of complaints **closed** during Quarter 2, 2023/24:

	Fully upheld: Complaint is accepted	Partially upheld: Complaint is partly accepted	Not upheld: Complaint is not accepted	Consent not received: Consent form not received from patient	No value	Total
Access - Improvements made to service access	1	1	0	0	0	2
Action plan(s) created and instigated	0	1	0	0	0	1
Communication - Improvements in communication staff-staff or staff-patient	4	6	0	0	0	10
Education/training of staff	2	0	0	0	0	2
No action required	0	0	6	1	0	7
System - Changes to systems	0	1	0	0	0	1
Share lessons with staff/patient/public	0	1	1	0	0	2
Waiting - Review of waiting times	2	0	0	0	0	2
No value **	0	1	0	1	0	2
Total	9	11	7	2	0	29*

**this figure does not represent number of complaints closed as complaints may have more than one action*
***no action required*

Table 2

Complaints Information Extracted from Lagan: **9** complaints were **closed** during Quarter 2, 2023/24

Directorate	Department	Service	Upheld	Partially Upheld	Not Upheld	Resolution	Grand Total
Health and Social Care Moray	Children and Families and Criminal Justice	Children and Families Area Teams	1	1	1	0	**3**
		Criminal Justice	0	0	0	1	**1**
		Reviewing Team	0	0	0	1	**1**
	Health and Social Care Moray	Access Team	1	1	0	0	**2**
		Care at Home	0	0	2	0	**2**

Table 3

Complaints Information Extracted from Datix: **25** complaints were **closed** during Quarter 2, 2023/24

	Fully upheld: Complaint is accepted	Partially upheld: Complaint is partly accepted	Not upheld: Complaint is not accepted	Consent not received: Consent form not received from patient	Total
Allied Health Professionals	0	2	0	0	2
Community Nursing	1	0	0	0	1
General Practice	0	0	1	0	1
GMED	3	4	1	1	9
MacMillan Nursing Service	1	0	0	0	1
Mental Health - Adult Mental Health	2	2	2	1	7
Mental Health - Old Age Psychiatry	0	0	1	0	1
Mental Health - Specialisms	0	0	1	0	1
Primary Care	0	0	1	0	1
Community Hospital	0	1	0	0	1
Total	7	9	7	2	25

Graph 1

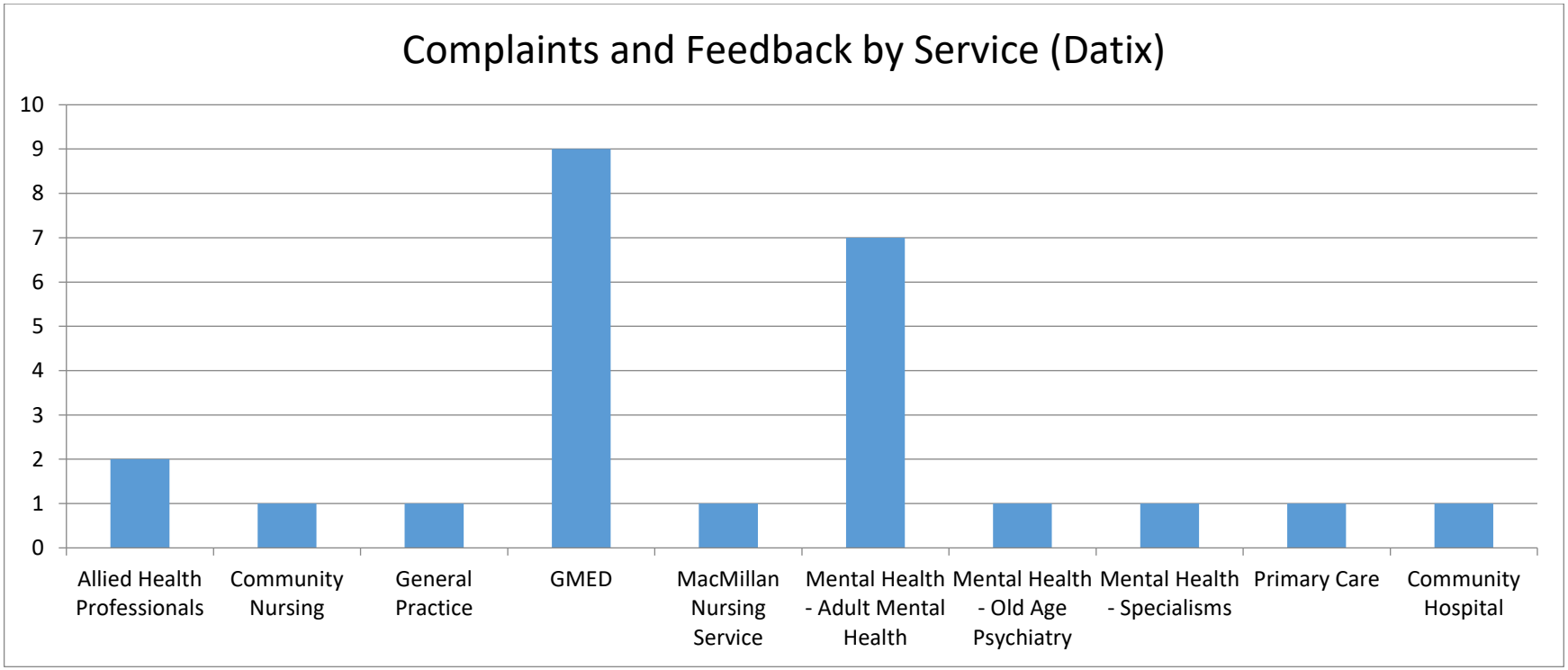

Complaints and Feedback by Service (Datix)
10
9
8
7
6
5
4
3
2
1
0
Allied Health Professionals
Community Nursing
General Practice
GMED
MacMillan Nursing Service
Mental Health - Adult Mental Health
Mental Health - Old Age Psychiatry
Mental Health - Specialisms
Primary Care
Community Hospital

Table 4

Complaints Information Extracted from Datix – Action Taken by Service (complaints **closed** during Quarter 2, 2023/24)

	Allied Health Professionals	Community Nursing	General Practice	GMED	MacMillan Nursing Service	Mental Health - Adult Mental Health	Mental Health - Old Age Psychiatry	Mental Health - Specialisms	Primary Care	No value	Total
Access - Improvements made to service access	0	0	0	1	0	1	0	0	0	0	2
Action plan(s) created and instigated	1	0	0	0	0	0	0	0	0	0	1
Communication - Improvements in communication staff-staff or staff-patient	0	1	0	5	1	2	0	0	0	1	10
Education/training of staff	0	0	0	2	0	0	0	0	0	0	2
No action required	0	0	0	1	0	3	1	1	1	0	7
System - Changes to systems	0	0	0	1	0	0	0	0	0	0	1
Share lessons with staff/patient/public	0	0	1	1	0	0	0	0	0	0	2
Waiting - Review of waiting times	0	0	0	1	0	1	0	0	0	0	2
No value**	1	0	0	1	0	0	0	0	0	0	2
Total	2	1	1	13	1	7	1	1	1	1	29*

**this figure does not represent number of complaints closed as complaints may have more than one action*
***no action required*

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

Table 5

Actions and Lessons Learned (Datix)

Education/Training	Signposting staff to relevant training materials to refresh knowledge
	Teams discussed need for timely note keeping
Communication/Reflection	Staff to reflect on consultation manner
Communication	Further promotion of use of e-consult forms
Access / Process Review	Review of triage protocol

Table 6

Learning Outcomes (Lagan)

Redress	General reminder to staff that when in virtual meetings with clients they should not speak to someone else who is also in the room
	Reminder to teams to ensure correspondence details for families are up to date and correct
Revision	Review of process to allow identification / reporting of difficulties to be done earlier.
	MDT arranged to ensure coordinated approach
	Team to review current processes for inviting parents and family to ensure that future action is taken if no response
Reinforcement	Clear guidance across agencies regarding information sharing and referring.

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

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

Table 7 – Total number of complaints **received** in Quarter 2, 2023/24

System recorded	Early Resolution / Frontline	Investigation	Not Marked	**Total**
NHS - Datix	**2** marked early resolution	**19** marked investigation	**0**	**21**
Moray Council - Lagan	**4** marked frontline	**9** marked investigative	**3** not yet marked	**16**
Total	**6**	**28**	**3**	**37**

Table 8 – Allocation of complaints **received** in Quarter 2, 2023/24

NHS Service - Datix	
GMED	6
Community Nursing	2
Adult Mental Health	10
AHP	2
Primary Care	1
Total	**21**

Table 9 – Allocation of complaints **received** in Quarter 2, 2023/24

MC Service - Lagan		
Children and Families and Criminal Justice	Fostering and Adoption and Supported Lodgings	1
	Children and Families Area Teams	6
	Reviewing Team	1
	Access Team	2
	Criminal Justice	1
	Throughcare	1
Health and Social Care Moray	Care at Home	4
Total		**16**

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

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

There were **25 Complaints closed** on the NHS system Datix during Quarter 2, 2023/24 – breakdown as follows:

Early Resolution – 2

Investigation – 21

SPSO – 2

There were **9 Complaints closed** on the MC system Lagan during Quarter 2, 2023/24 – breakdown as follows:

Frontline – 4

Investigation – 4

Escalated Investigative – 1

Table 10 – number and percentage of complaints at each stage closed within timescales **(based on complaints closed during Quarter 2, 2023/24)**

	Frontline/Early Resolution within timescale	Investigation within timescale
NHS - Datix	2 out of 2 (100%)	5 out of 21 (24%)
Moray Council - Lagan	0 out of 4 (0%)	2 out of 4 (50%)

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

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

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

Table 11 – *average time in working days to respond at stage 1, stage 2 and after escalation* **(based on complaints closed during Quarter 2, 2023/24)**

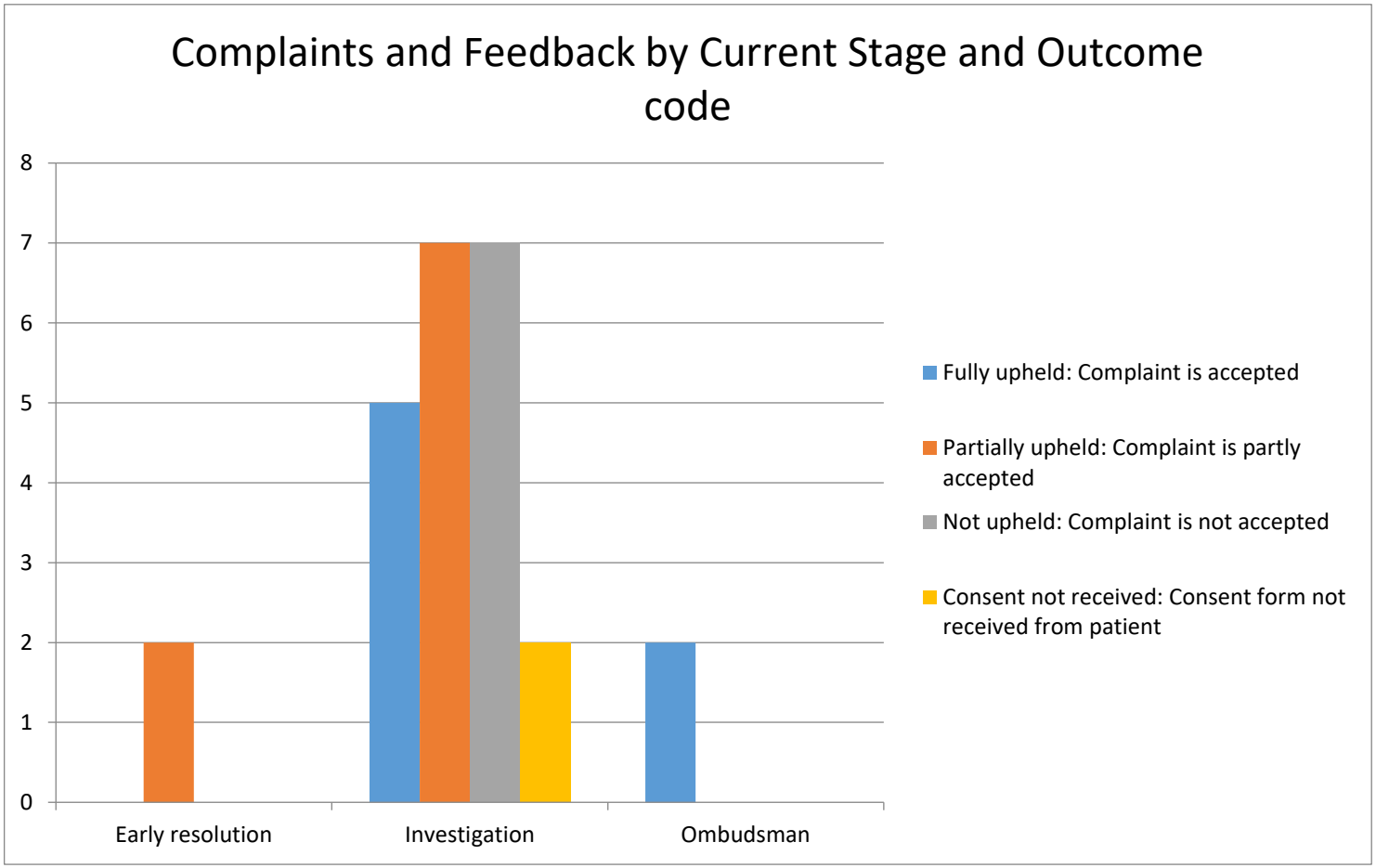
	Frontline	Investigative
NHS - Datix	3 days	54 days
Moray Council - Lagan	18 days	15 days

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

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

Graph 2 below shows the number of complaints fully upheld, partially upheld and not upheld as recorded in Datix during Quarter 2, 2023/24.

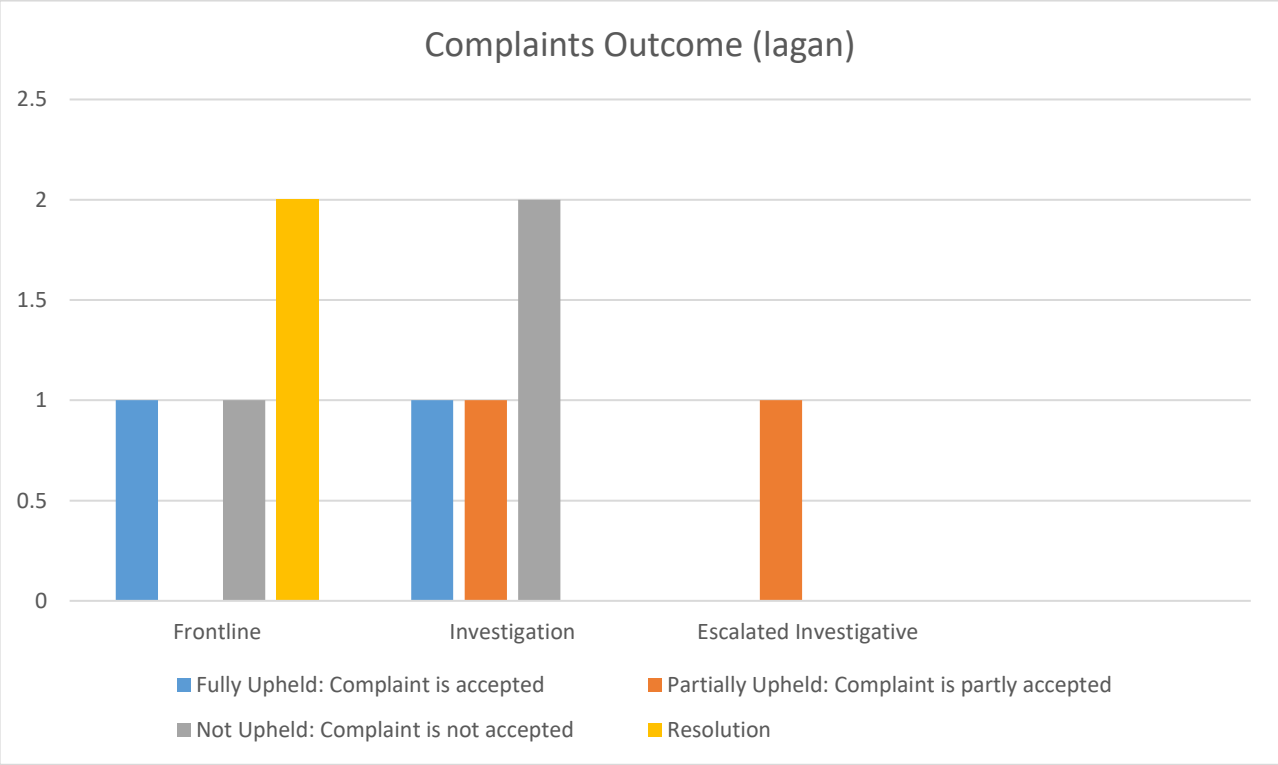
25 complaints were closed during Quarter 2: 2 were closed due to no consent – from the remaining 23 closed complaints 30.5% were upheld, 39% were partially upheld and 30.5% were not upheld



Complaints Information Extracted from Lagan:

9 complaints were **closed** during Quarter 2, 2023/24: **approx. 22% were fully upheld, 22% partially upheld, 33% were not upheld and 22% were resolved.**

Graph 3 below shows the amount of complaints upheld, partially upheld and not upheld as recorded in Lagan from the **9 closed** complaints during Quarter 2, 2023/24.



REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 30NOVEMBER 2023**

SUBJECT: **INSPECTION OF FOSTERING, ADOPTION AND ADULT PLACEMENT JUNE/JULY 2023**

BY: **HEAD OF SERVICE AND CHIEF SOCIAL WORK OFFICER**

1. REASON FOR REPORT

1.1 To update the Committee following a full inspection of Placement Services (fostering, adoption and adult placement) by the Care Inspectorate in June/July 2023.

2. RECOMMENDATION

2.1 It is recommended that the Committee scrutinise and note the outcome of the full inspection of Placement Services (fostering, adoption and adult placement) by the Care Inspectorate in June/July 2023.

3. BACKGROUND

3.1 Fostering, adoption and adult placement are inspected on a regular basis by the Care Inspectorate.

3.2 Adult placement is a service where young people remain in the same placement when they reach eighteen years of age. This provides continuity and stability for young people supporting transition from childhood to adulthood.

3.3 The inspection in July 2023 was preceded by an inspection of the same services in March 2022. As such, the inspection in June/July 2023 should be viewed as a follow up inspection which was the approach of the Care Inspectorate.

3.4 The inspection in March 2022 identified a number of areas requiring significant improvement.

3.5 The Care Inspectorate use a Six-Point Scale for grading as follows:

Grading	Description
6	Outstanding or sector leading
5	Major strengths
4	Important strengths, with some areas for improvement
3	Strengths just outweigh weaknesses
2	Important weaknesses - priority action required
1	Major weaknesses - urgent remedial action required

3.6 The gradings provided by the Care Inspectorate in March 2022 were as follows:

Quality Indicator	Fostering	Adoption	Adult Placement
1.1	4	4	5
1.2	3	4	4
1.3	3	3	5
1.4	2	2	4
2.2	3	3	4
3.2	3	3	3
5.1	3	2	4

3.7 The outcome of the March 2022 inspection was presented to the Education, Children's & Leisure Services Committee (ECLS) on 14 December 2022 (para 5 of minute refers). A further progress report was requested which was presented to ECLS Committee on 19 April 2023 (para 8 of minute refers) in advance of the transfer to the Moray Integrated Joint Board (MIJB).

3.8 At the ECLS Committee on 19 April 2023 a number of areas of improvement and progress were outlined. These areas were being addressed within a Service Improvement Plan and included management stability, recruitment and retention of staff, training and induction for staff, improved processes and procedures, permanence planning, training for foster carers and adopters, and the approach towards foster carers who go on to adopt the children they care for.

3.9 It was reported to ECLS Committee on 19 April 2023 that it was hoped that this improvement work would result in a more positive outcome when the follow up inspection of fostering, adoption and adult placement by the Care Inspectorate was undertaken.

4. KEY MATTERS RELEVANT TO THE RECOMMENDATIONS

4.1 The Care Inspectorate undertook the anticipated follow up full inspection of Placement Services (fostering, adoption and adult placement) in June/July 2023.

4.2 Placement Services were notified by the Care Inspectorate on 10 May 2023 that it would be undertaking an inspection of fostering, adoption and adult placement commencing on 12 June 2023.

4.3 The Care Inspectorate identified that it was continuing with the new style of hybrid inspection as a consequence of the Covid-19 pandemic.

4.4 This new model provided Placement Services with four weeks in order to gather documents and information requested by the Care Inspectorate. This was then followed by four weeks of the inspection. The first week of the inspection was an off-site reading week, with the second and third weeks comprising online and face to face meetings, where appropriate, with young people, carers and staff.

4.5 The inspection was undertaken by two inspectors. There was a positive working relationship with the inspectors with effective communication via telephone, email and weekly catch up meetings. It was reported by young people, carers and staff that the inspectors were professional and respectful.

4.6 The Care Inspectorate assessed Placement Services against seven quality indicators set out in “A quality framework for fostering, adoption and adult placement services” (May 2021) (**Appendix 1**).

4.7 In the four weeks of preparation time, Placement Services formed a task and finish working group with the purpose of gathering, collating, reviewing and sending documents and information to the Care Inspectorate. This group then oversaw the process and management of the four week inspection process itself.

4.8 The working group undertook its role successfully where the Care Inspectorate praised Placement Service’s open, transparent and organised approach to the inspection.

4.9 The Care Inspectorate provided initial verbal feedback on 6 July 2023. Placement Services were provided with the draft inspection reports with an opportunity to provide feedback to the Care Inspectorate prior to final publication.

4.10 The final reports are attached for the Fostering Service (**Appendix 2**), the Adoption Service (**Appendix 3**) and Adult Placement (**Appendix 4**).

4.11 The gradings provided by the Care Inspectorate for the June/July 2023 are as follows:

Quality Indicator	Fostering	Adoption	Adult Placement
1.1	4	5	5
1.2	4	5	4
1.3	4	4	5
1.4	4	4	4
2.2	4	4	4
3.2	4	4	4
5.1	4	4	4

4.12 In this table the colour coding key is:

(i) amber indicates grade maintained from March 2022
(ii) green indicates grade improved from March 2022

4.13 The feedback from the Care Inspectorate identified that this inspection was a significant improvement on the March 2022 inspection.

4.14 The table in 4.11 identifies that the fostering service improved in six areas and maintained progress in one; it was also able to improve Quality Indicator 1.4 by two grades from 2 to 4. The adoption service improved in all seven areas and was also able to improve Quality Indicators 1.4 and 5.1 by two grades both from 2 to 4. The adult placement service maintained progress in six areas and improved in one.

4.15 Overall, this was a positive outcome where the fostering service and the adoption were assessed as having made significant improvements and progress. Most significantly, the fostering and adoption services were no longer graded as either 2 (Weak) or 3 (Adequate) in any areas. The adult placement service was assessed as having maintained progress with this being from a higher starting point than the foster and adoption services.

4.16 In the final inspection reports in respect of fostering, adoption and adult placement the Care Inspectorate gave all three services each an overall grade of 4 (Good) in all areas.

4.17 In the final feedback the Care Inspectorate identified that although there had been significant progress, it was too soon to assess whether this change was fully embedded. It indicated that this would be the focus of the next inspection of fostering, adoption and adult placement. The Care Inspectorate identified that areas for improvement included, for example, maintaining relationships between siblings who are not placed together and ensuring that tracking systems are in place to monitor outcomes.

4.18 Following the inspection, Placement Services has continued its improvement activity via the ongoing Service Improvement Working Group. This is a working group which oversees a programme of continuous improvement via a Service Improvement Plan (SIP).

4.19 Placement Services is committed to continuing the progress identified by the Care Inspectorate in the inspection of June/July 2023. This will include embedding current progress and identifying stretch aims via the SIP. In this respect, Placement Services identifies itself as a learning service with a focus on continuous improvement.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"

The Corporate Plan 2024 makes a commitment to improving outcomes for Moray's most vulnerable young people and families and that more children will live with their families, being cared for in strong safe, communities across Moray.

(b) Policy and Legal
The Care Inspectorate assessed Placement Services against seven quality indicators set out in "A quality framework for fostering, adoption and adult placement services" (May 2021) (Appendix 1).

(c) Financial Implications
There are no financial implications.

(d) Risk Implications and Mitigation
There are no risk implications and mitigation.

(e) Staffing Implications
There are no staffing implications.

(f) Property
There are no property implications.

(g) Equalities/Socio Economic
There are no implications in relation to equalities/socio economic impact.

(h) Climate Change and Biodiversity Impacts
There are no climate change or biodiversity impacts.

(i) Directions
None.

(j) Consultations
Chief Officer, Health and Social Care Moray; Chief Social Work Officer & Head of Service; Head of HR, ICT and Organisational Development; Chief Financial Officer; Caroline O'Connor, Committee Services Officer and the Equal Opportunities Officer have been consulted in the preparation of this report and are in agreement with the content relating to their areas of responsibility.

6. CONCLUSION

6.1 It is recommended that the Committee scrutinise and note the outcome of the full inspection of Placement Services (fostering, adoption and adult placement) by the Care Inspectorate in June/July 2023.

Author of Report: Carl Campbell, Service Manager
Ref:

care inspectorate

A quality framework for fostering, adoption and adult placement services

For use in self-evaluation, scrutiny and improvement support

May 2021

1. Changes to our inspection

We are developing new approaches to scrutiny. We want to make sure that inspections and our other scrutiny work are strongly focused on assessing the extent to which people experience wellbeing, and on understanding the difference care and support makes to their lives.

Since 1 April 2018, the Health and Social Care Standards have been used across Scotland. They have been developed by Scottish Government to describe what people should experience from a wide range of care and support services. They are relevant not just for individual care services, but across local partnerships. The Care Inspectorate's expectation is that they will be used in planning, commissioning, assessment and in delivering care and support. We will use them to inform the decisions we make about care quality. This means that we are changing how we inspect care and support. From 2018, on an incremental basis, we have been rolling out a revised methodology for inspecting care and support services.

The changes build on approaches we have introduced in the past three years: an emphasis on experiences and outcomes; proportionate approaches in services that perform well; shorter inspection reports; and a focus on supporting improvement in quality. The core of the new approach is a quality framework that sets out the elements that will help us answer key questions about the difference care is making to people and the quality and effectiveness of the things that contribute to those differences. The primary purpose of a quality framework is to support services to evaluate their own performance. The same framework is then used by inspectors to provide independent assurance about the quality of care and support. By setting out what we expect to see in high-quality care and support provision, we can also help support improvement. Using a framework in this way develops a shared understanding of what constitutes good care and support.

It also supports openness and transparency in the inspection process. In developing this framework, we have involved both people who experience or have experienced care and those who provide care and support. It is based on the approach used by the European Foundation for Quality Management, specifically the EFQM Excellence Model, which is a quality tool widely used across sectors and countries. We have adapted the model for use in care settings and have used the new Health and Social Care Standards to illustrate the quality we expect to see. Our frameworks are tested and evaluated to hear the views of people experiencing care, their carers and care providers. This helps us refine the framework and the way we will use it.

How is the framework structured?

The quality framework is framed around six **key questions**. The first of these is:

- How well do we support people's wellbeing?

To try and understand what contributes to wellbeing, there are four further key questions:

- How good is our leadership?
- How good is our staff team?
- How good is our setting?
- How well is care and support planned?

Under each key question, there are a small number of **quality indicators**. These have been developed to help answer the key questions. Each quality indicator has a small number of **key areas**, short bullet points which make clear the areas of practice covered.

Under each quality indicator, we have provided **quality illustrations** of these key areas at two levels on the six-point scale used in inspections. The illustrations are the link to the Health and Social Care Standards and are drawn from the expectations set out in the Standards. They describe what we might expect to see in a care service that is operating at a 'very good' level of quality, and what we might see in a service that is operating at a 'weak' level of quality. These illustrations are not a definitive description of care and support provision but are designed to help care services and inspectors evaluate the quality indicators, using the framework.

The final key question is:

- What is our overall capacity for improvement?

This requires a global judgement based on evidence and evaluations from all other key areas. The judgement is a forward-looking assessment, but also takes account of contextual factors which might influence the organisation's capacity to improve the quality of the service in the future. Such factors might include changes of senior staff, plans to restructure, or significant changes in funding. We think this an important question to ask as part of self-evaluation.

In each quality indicator, we have included a **scrutiny and improvement toolbox.** This includes examples of the scrutiny actions that we may use in evaluating the quality of provision. It also contains links to key practice documents that we think will help care services in their own improvement journey.

How will this quality framework be used on inspections?

The quality framework will be used by inspectors in place of the older approach of 'inspecting against quality themes and statements'. Inspectors will look at a selection of the quality indicators. Which, and how many quality indicators will depend on the type of inspection, the quality of the service, the intelligence we hold about the service, and risk factors that we identify, but it is likely that we will always inspect quality indicators 1.1, 1.2, 1.3 as well as 5.1. In our professional evaluations of the care and support we see, we will use the quality illustrations.

One of the quality indicators, 1.4, looks beyond the practice of an individual care service and introduces elements about the impact of planning, assessment and commissioning on people experiencing care. This is important because these practices impact on people's experiences and the extent to which they experience wellbeing. This quality indicator may help us during an inspection to find information or intelligence which is relevant to practices in commissioning partnerships, but our overall inspection evaluations (grades) will reflect the impact and practice of the care service itself.

We will provide an overall evaluation for each of the key questions we inspect, using the six-point scale from 'unsatisfactory' (1) to 'excellent' (6). This will be derived from the specific quality indicators that we inspect. Where we inspect one quality indicator per key question, the evaluation for that quality indicator will be the evaluation for the key question. Where we inspect more than one quality indicator per key question, the overall evaluation for the key question will be the lower of the quality indicators for that specific key question. This recognises that there is a key element of practice that makes the overall key question no better than this evaluation.

How we will use the six-point scale?

The six-point scale is used when evaluating the quality of performance across quality indicators.

6	Excellent	outstanding or sector leading
5	Very good	major strengths
4	Good	important strengths, with some areas for improvement
3	Adequate	strengths just outweigh weaknesses
2	Weak	important weaknesses – priority action required
1	Unsatisfactory	major weaknesses – urgent remedial action required

An evaluation of **excellent** describes performance which is sector leading and supports experiences and outcomes for people which are of outstandingly high quality.

There is a demonstrable track record of innovative, effective practice and/or very high-quality performance across a wide range of its activities and from which others could learn. We can be confident that excellent performance is sustainable and that it will be maintained.

An evaluation of **very good** will apply to performance that demonstrates major strengths in supporting positive outcomes for people. There are very few areas for improvement. Those that do exist will have minimal adverse impact on people's experiences and outcomes. While opportunities are taken to strive for excellence within a culture of continuous improvement, performance evaluated as very good does not require significant adjustment.

An evaluation of **good** applies to performance where there is a number of important strengths which, taken together, clearly outweigh areas for improvement. The strengths will have a significant positive impact on people's experiences and outcomes. However, improvements are required to maximise wellbeing and ensure that people consistently have experiences and outcomes which are as positive as possible.

An evaluation of **adequate** applies where there are some strengths, but these just outweigh weaknesses. Strengths may still have a positive impact but the likelihood of achieving positive experiences and outcomes for people is reduced significantly because key areas of performance need to improve. Performance which is evaluated as adequate may be tolerable in particular circumstances, such as where a service or partnership is not yet fully established, or in the midst of major transition. However, continued performance at adequate level is not acceptable. Improvements must be made by building on strengths while addressing those elements that are not contributing to positive experiences and outcomes for people.

An evaluation of **weak** will apply to performance in which strengths can be identified but these are outweighed or compromised by significant weaknesses. The weaknesses, either individually or when added together, substantially affect children's experiences or outcomes. Without improvement as a matter of priority, the welfare or safety of people may be compromised, or their critical needs not met. Weak performance requires action in the form of structured and planned improvement by the provider or partnership with a mechanism to demonstrate clearly that sustainable improvements have been made.

An evaluation of **unsatisfactory** will apply when there are major weaknesses in critical aspects of performance which require immediate remedial action to improve experiences and outcomes for people. It is likely that people's welfare or safety will be compromised by risks which cannot be tolerated. Those accountable for carrying out the necessary actions for improvement must do so, as a matter of urgency, to ensure that people are protected, and their wellbeing improves without delay.

How can this quality framework be used by care services?

The framework is primarily designed to support care services in self-evaluation. We are working with care services and sector-wide bodies to build the capacity for self-evaluation, based on this framework. We have published 'Self-evaluation for improvement – your guide. The guide is available **here**.

Self-evaluation is a core part of assuring quality and supporting improvement. The process of self-evaluation, as part of a wider quality assurance approach, requires a cycle of activity based around three questions:

- **How are we doing?**

This is the key to knowing whether you are doing the right things and, as result, people are experiencing high quality, safe and compassionate care and support that meets their needs, rights and choices.

- **How do we know?**

Answering the question 'how are we doing' must be based on robust evidence. The quality indicators in this document, along with the views of people experiencing care and support and their carers, can help you to evaluate how you are doing. You should also take into account performance data collected nationally or by your service.

- **What are we going to do now?**

Understanding how well your service is performing should help you see what is working well and what needs to be improved. From that, you should be able to develop plans for improvement based on effective practice, guidance, research, testing and available improvement support.

Using this quality framework can help provide an effective structure around self-evaluation. The diagram below summarises the approach:

Irrespective of our role as the national scrutiny and improvement body, care providers will want to satisfy themselves, their stakeholders, funders, boards and committees that they are providing high quality services. We believe this quality framework is a helpful way of supporting care services to assess their performance against our expectations of outcomes for children and young people, outwith the assessment process.

2. The quality indicators

Key question 1: How well do we support people's wellbeing?	Key question 2: How good is our leadership?	Key question 3: How good is our staff team?	Key question 4: How good is our setting?	Key question 5: How well is our care and support planned?
1.1 Children, young people, adults and their caregiver families experience compassion, dignity and respect.	**2.1** Vision and values positively inform practice.	**3.1** Staff have been recruited well.	Not currently being assessed for these service types.	**5.1** Assessment and care planning reflects the outcomes and wishes of children, young people and adults .
1.2 Children, young people and adults get the most out of life.	**2.2** Quality assurance and improvement are led well.	**3.2** Staff have the right knowledge, competence and development to support children, young people, adults and their caregiver families.		**5.2** Parents, carers and family members are involved.
1.3 Children, young people and adults' health and wellbeing benefits from the care and support they experience.	**2.3** Leaders collaborate to support children, young people, adults and their caregiver families. well.	**3.3** Staffing arrangements are right and staff work well together.		
1.4 Children, young people, adults and their caregiver families get the service that is right for them .	**2.4** Staff are led			
Key question 6: What is the overall capacity for improvement?				

This framework is for fostering, adoption and adult placement, including shared lives services. It sets out outcomes for children, young people, adults and their caregivers across the whole range of these service types.

Family-based services provide a highly personalised form of care that supports people with a wide range of ages and support needs to live within a family setting. It differs from other types of care provided in a home setting as the person being cared for becomes part of the caregiver's family.

In order to identify outcomes that are relevant to the service, you should consider the aims and objectives of the service when looking at the quality illustrations and evaluating it using the quality indicators and key questions.

The use of the term 'people'

Thoughout the development of this framework, there have been various discussions around the status of caregivers, a term we have assigned collectively to adult placement carers, foster carers and adoptive parents. We considered including the quality of caregivers within the staffing section however the Independent Care Review took a much more holistic view of family. They refer to families as 'biological, kinship, adoptive, foster and others'. This was in response to children and young people often feeling a sense of family when living within these situations.

The review goes on to address the need for responsive, flexible, timely, intensive supports being available to children, young people and their families to support stable living situations. We have tried to address this view within the framework and decided that 'key question 1' would include the extent to which children, young people, adults and their caregiver families were supported.

Collectively we have used the term 'people' to capture all these groups within the quality illustrations.

We have spoken about people throughout this framework and have separated this into:

- **People who live within caregiver families** - These are the children, young people and adults who are looked after or being cared for.
- **People – everyone being supported by the service**. This includes the people above and additionally, the caregiver and their family.

Key question 1: How well do we support people's wellbeing?

This key question has four quality indicators:

1.1 Children, young people, adults and their caregiver families experience compassion, dignity and respect.

1.2 Children, young people and adults get the most out of life.

1.3 Children, young people and adults' health and wellbeing benefits from the care and support they experience.

1.4 Children, young people, adults and their caregiver families get the service that is right for them.

Quality Indicator 1.1: Children, young people, adults and their caregiver families experience compassion, dignity and respect.

Key areas include the extent to which children, young people and adults:

- experience compassion
- have their rights respected, and experience dignity and a life free from discrimination
- are involved in decision making.

Quality illustrations	
Very good	**Weak**
People develop meaningful, affectionate and secure relationships with their caregiver families. Relationships are based on empathy, compassion, trust, predictability, love and fun. Caregivers and staff within the service have a very enabling attitude and foster belief in the potential of the individual child, young person or adult. People living within caregiver families have a strong sense they are part of the family. Caregiver families enjoy enduring, positive relationships with staff within the service. They are actively supported and encouraged, through training and reflective practice discussions, to provide loving, nurturing families for people who may have experienced a range of broken attachments and difficult early lives.	People who live with caregiver families do not feel that the family looking after them like, know or value them as individuals. They feel excluded from family life such as celebrations, holidays and outings. They may feel alone, unsupported and uncertain about their place in the family. Staff do not recognise the need to continue to support caregiver families throughout their experience of caring. Support is limited to times when they are caring for people and is not available when people have moved on or when family circumstances change. Staff do not know about the Health and Social Care Standards, or they are not clear about how the principles should inform their practice.

Quality illustrations	
Very good	**Weak**
People experience a high level of respect from everyone involved in their care and support. Caregiver families and staff within the service understand the importance of safeguarding the privacy and confidentiality of the people in their care. People who live in a caregiver family feel accepted and valued regardless of their individual circumstances, physical or emotional needs. They know that their caregiver family and staff within the service will recognise and challenge any form of discrimination.	People who live in caregiver families, experience unnecessary or insensitive intrusions on their privacy. Their personal records and information may be inaccurate, not stored securely or be shared inappropriately with others either by their caregiver family or by staff within the service. They receive limited support or information to understand their rights. Caregiver families are not supported to understand or take enough account of diversity. They do not appreciate a person's culture, language, religion or spirituality, sexuality or gender identity.
The very good quality of relationships actively supports people who live in caregiver families to know and fully exercise their legal and human rights including their rights as a citizen, for example voting in elections. Caregiver families recognise and embrace the unique circumstances of each individual and support people to explore different aspects of their lives whether these are cultural, religious or sexual orientation.	Restrictions on choices and independence are not based on the needs of the child, young person or adult.

Quality illustrations	
Very good	**Weak**
People who live in caregiver families are well informed about and actively involved in decisions about their care in ways which are meaningful to them. Ready access to specialist services and tools ensures that where there are communication difficulties or disabilities, people continue to be fully included in all aspects of their support, family life and decision making. Caregiver families advocate passionately and effectively on behalf of people living in their family. They are recognised as significant people in the decision-making process and, as such, have their views listened to and respected in relation to the people for whom they are caring. Advocacy services including independent advocacy is available to people should they wish this	The approach to inclusion and participation for people living in caregiver families is superficial or their views do not consistently make a difference. They have limited access to either informal or independent advocacy. People feel powerless or not listened to in decision making because staff fail to give appropriate regard to or act on views which are seen as challenging. Attempts to involve people who are seen as difficult to engage are not given sufficient priority. Involvement in decision-making of those with additional needs is tokenistic or limited because of perceived challenges or time constraints

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Obtain the views of people, caregiver family, birth family (where appropriate), friends, visitors, staff, managers and other professionals. • Seek confirmation of positive relationships through visiting the caregivers home and meeting the caregiver, their family and people they are supporting. • Examine records for evidence of how people's rights are respected and their views obtained and acted on. Consider complaint and duty of candour records for the service's response to issues and concerns. • Review the extent to which relevant policies and procedures, for example confidentiality, equality and diversity, are implemented and influence care and support. • Consider people's access to advocacy and the use of communication support tools in obtaining their views. • Examine any restrictions to people's liberty and freedom of choice, whether these are justified, and how they have been explained. • Review how people are informed about their rights, for example in admission information.	The Health and Social Care Standards: **Health and Social Care Standards: My support, my life (www.gov.scot)** The Independent Care Review: **https://www.carereview.scot/** The Love Inc Project: **https://www.aberlour.org.uk/services/love-inc-project/** Scottish Human Rights Commission: **https://www.scottishhumanrights.com/** Mental Welfare Commission • Rights, risks and limits to freedom • Advocacy • Covert Medication • Working with the AWI Act • Decisions about Technology. **https://www.mwcscot.org.uk/publications** Scotland's national action plan for human rights: **CELCIS: The power of human rights to improve people's health and care** Practice Guide - involving children and young people in improving services: **https://hub.careinspectorate.com/media/1582/practice-guide-involving-children-and-young-people-in-improving-services.pdf** Charter for Involvement **charter-for-involvement-2019.pdf (arcscotland.org.uk)**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	7 golden rules or participation and other rights information: **https://www.cypcs.org.uk/rights** Your Rights to Care: **Rights-To-Care-Booklet.pdf (cypcs.org.uk)** Who Cares? Scotland: **www.whocaresscotland.org**

Quality Indicator 1.2: Children, young people and adults get the most out of life

Key areas include the extent to which children, young people and adults living within caregiver families:

- make decisions and choices about their lives and how they spend their time
- lead active and fulfilling lives.

And the extent to which everyone being supported by the service:

- have positive learning experiences, achieve their goals and aspirations and reach their potential
- feel safe and are protected from abuse, harm, neglect and bullying.

Quality illustrations	
Very good	**Weak**
People living within caregiver families routinely exercise a high degree of choice in all aspects of their day-to-day lives within an overall family context. They experience highly personalised care and support that is enriched by caregiver families who understand their individual strengths and preferences. People who want or need to spend time away from their caregiver family can develop a range of relationships out-with the family. Short breaks are planned in advance. Consistency and stability are prioritised and people view short times of being cared for by others, as part of an extended family experience.	People living within caregiver families have little autonomy and are expected to fit in with what is happening within the home with little opportunity to influence family life. The quality of their experiences is lessened by assumptions about what is safe or possible. Caregivers do not consider the changing needs and preferences of the people in their care. Time away from the caregiver family is poorly planned, inconsistent and stressful. People may not know or have met the family who is going to care for them and this can have a significant detrimental impact on wellbeing.

Quality illustrations	
Very good	**Weak**
Positive relationships with others including family and friends are encouraged and promoted by the caregiver family. Where these arrangements are determined by a legal order, people are supported to understand the decisions and their rationale. People can choose to be active members of their own local community or the community in which their caregiver family live. They are routinely supported to meet new people, develop individual interests and have fun. As a result, they have a strong sense of belonging and worth. They are enabled to feel fulfilment in life, and to create positive memories. This includes planning and taking part in holidays with their caregiver family. Children and young people are living with their siblings, unless this has been assessed as not appropriate. In these situations, the rights of children and young people to have meaningful relationships, celebrate special family occasions and make new treasured memories with siblings is recognised and actively promoted.	People who live with caregiver families do not feel part of the family or local community. Their sense of belonging and identity are compromised because they are isolated from their birth families and local community without justification. People are not supported to form friendships. They are less able to benefit from the opportunities provided by a diversity of relationships or membership of groups and networks Opportunities to take part in meaningful activities are limited or aimed at whole family activities rather than based on individual need and choice. Siblings are separated due to a lack of understanding of the complexity of their relationships given their shared early experience. Meaningful contact, including sharing special occasions, between separated siblings is regularly interrupted due to poor planning or a lack of resources.

Quality illustrations	
Very good	**Weak**
When in education, people living in caregiver families receive individually tailored support to engage fully in learning and maximise attainment as well as attendance. This may include additional or individual tuition. Where challenges or barriers exist, caregiver families and staff successfully champion the right to a high quality, inclusive education. Caregivers understand the need to provide educationally rich environments with appropriate space and resources to study and learn. People living within caregiver families making a transition from one education setting to another, receive high quality, planned support to do so successfully. When they leave school or college, they receive support to move to positive and sustained destinations. Being meaningfully engaged in education, work or planned activities is the norm for everyone living within a caregiver family. With the support of their caregiver families, at the right time and pace, people develop a wide range of life skills. These promote confidence and help them to get the most out of life. There is a culture of ambition and celebration when people living within caregiver families strive for and achieve. These successes are used to build optimism and foster further progress..	When in education people are disadvantaged because there is no perceived value placed on learning or the support they receive is limited or takes little account of individual needs or strengths. School and college attendance is low, or people receive limited targeted support for successful learning and may fall behind. They are not enabled to play a full part in school life. There is limited collaboration with schools and other learning providers to help reduce the impact of adverse experiences or overcome stigma. People and their caregiver families have low expectations about what they should aspire to and can achieve. There is a lack of clarity about what is available or what is expected. They feel they do not receive enough encouragement to reach their potential and the quality of learning resources is stale and uninteresting. People living in caregiver families have limited opportunities to practise the skills they will need in adulthood or to live interdependently. There is an over-emphasis on them achieving 'independence' rather than living interdependently. Learning and development programmes for caregiver families are service-led or based on what is already available rather than the development of suitable, individualised approaches to learning needs

Quality illustrations	
Very good	**Weak**
This ambition extends to caregivers who embark on ongoing learning and development to support them to continue to provide therapeutic, nurturing family environments and better meet the needs of the people they look after.	
People living within caregiver families are kept safe both emotionally and physically. This includes caregiver families ensuring that people can access the internet and social media safely. Caregiver families benefit from staff supporting them to identify any concerns early and to take action to support the people in their care. Caregiver families are encouraged to actively engage and work in partnership with other agencies. The service fully implements national guidance and best practice in child and adult protection, including sexual exploitation and challenges decision making if necessary or appropriate. People living within caregiver families are supported by their caregiver family to develop the skills and knowledge they need to understand risk, make informed decisions and make their lives as safe as possible. Adults understand their right to make choices and take informed personal risk. People living within caregiver families always have access to responsible people outside the service or in other organisations, who consistently act in their best interests and provide additional support and safeguards.	Children, young people and adult's safety and wellbeing, and the extent to which they feel protected, may be compromised by a failure to identify and respond to indicators of concern. The needs of those with disabilities or who are less able to communicate their experiences do not receive enough attention. People who live in caregiver families may not feel involved in, or well-informed about decisions that are made about their protection. People living in caregiver families do not learn how to promote their own safety and wellbeing. Networks of support for children, young people and vulnerable adults outside the home are limited and do not provide the additional safeguards required. Children, young people and adults experience bullying or may be hurt, feel threatened, afraid or excluded. Their wellbeing is affected by insensitive or inconsistent responses when bullying occurs. The service does not have a preventative approach to bullying.

Quality illustrations	
Very good	**Weak**
People living within caregiver families are confident that their caregiver family will be supported by staff to recognise and effectively challenge all forms of bullying, including prejudice-based bullying. Caregiver families benefit from staff who support them during times of difficulty, including where allegations have been made against them.	

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Speak with people living in caregiver families, family members, visitors, staff, managers and other professionals. • Seek confirmation of positive relationships through visiting the caregiver's home and meeting the caregiver, their family and people they are supporting. • Review people's suggestions, comments and requests and how the service responds. • Examine people's records, including assessments, plans and reviews, and the extent to which they demonstrate they are safe, active, achieving, respected and responsible. • Review the effectiveness of support for people to attend school, college or work. Consider how the service supports wider learning and achievement outside the formal education setting.	Autism strategy for Scotland: **https://www.scottishautism.org/about-autism/strategy-policy-initiatives/scottish-strategy-autism** Care...about physical activity: **Care...about physical activity | Care Inspectorate Hub** The Keys to Life: **https://keystolife.info/** Adult support and protection: **https://www.gov.scot/policies/social-care/adult-support-and-protection/** Disability rights UK– doing sports differently: **DoingSportDifferentlyJune2017.pdf (disabilityrightsuk.org)** Wellness recovery action plan: **https://mentalhealthrecovery.com/**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• Consider the relevance, variety and quality of caregiver learning and development, adherence to core training requirements and the impact of training on supporting positive outcomes for people • Review relevant policies and procedures, child and adult protection records, incident records, staff and caregiver training and their understanding of their responsibilities. • Consider people's access to protective adults and supports outside the home.	Promoting excellence in dementia care (includes people with a learning disability and dementia): **https://www.sssc.uk.com/supporting-the-workforce/self-directed-support-and-integration/dementia-learning-and-promoting-excellence/** Mental Welfare Commission – good practice guidance: **https://mwcscot.org.uk/publications?type=39** Information on supporting people with complex needs and sight loss: **https://www.rnib.org.uk/professionals-social-care-professionals/complex-needs-social-care** Good communication standards: **https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/5-good-comms-standards-easy-read.pdf** Stand up for siblings: **https://www.standupforsiblings.co.uk/** Useful resources on contact for children: **https://www.nuffieldfjo.org.uk/resources** Learning in care: **https://hub.careinspectorate.com/media/1546/learning-in-care-activities-for-professionals-who-work-with-children-in.pdf** Celebrating success: what helps looked after children succeed. **https://www.celcis.org/files/3814/6669/2296/celebrating_success_2006.pdf**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	National guidance for child protection in Scotland: https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2014/05/national-guidance-child-protection-scotland/documents/00450733-pdf/00450733-pdf/govscot%3Adocument/00450733.pdf?forceDownload=true Child sexual exploitation: definition and practitioner briefing paper: https://www.gov.scot/publications/child-sexual-exploitation-definition-practitioner-briefing-paper/ National guidance for child protection in Scotland: additional notes for practitioners: protecting disabled children from abuse and neglect: https://www.gov.scot/publications/national-guidance-child-protection-scotland-2014-additional-notes-practitioners-protecting-disabled-children-abuse-neglect/ National Missing Persons Framework for Scotland: https://www.gov.scot/publications/national-missing-persons-framework-scotland/ On Risk (IRISS): A publication about risk being a natural part of decision making, the complexity of sharing risk between professionals and people using services and our personal and organisational tolerance to risk. https://www.iriss.org.uk/resources/irisson/risk Scotland Works for You Guidance Pack https://www.mygov.scot/scotland-works-for-you/

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Managing allegations against foster carers: https://www.gov.scot/publications/managing-allegations-against-foster-carers-approved-kinship-carers-agencies-respond

Quality Indicator 1.3: Children, young people and adults' health and wellbeing benefits from the care and support they experience

Key areas include the extent to children, young people and adults living in caregiver families:

- experience care and support based on relevant research, guidance, standards and good practice
- have the highest attainable standards of physical and mental health
- have good nutrition, enjoy their food and learn about healthy eating.

Quality illustrations	
Very good	**Weak**
People living in caregiver families thrive, develop a strong sense of identity and positive mental health. This is supported by stable living situations, positive, predictable relationships with caregivers and appropriate timely, supportive interventions. Staff support and equip caregiver families, to share information sensitively and creatively with people about their life story. People living within caregiver families are supported to understand their history in a manner which is right for them. People living in caregiver families consistently experience care and support that reflects their developmental stage and needs, and is nurturing, attachment-based and trauma aware. A range of credible, high-quality interventions enables them to build emotional regulation, resilience and self-esteem. Their capacity for growth and change is recognised and promoted.	People living in caregiver families have their emotional wellbeing and development compromised by a lack of stable, secure attachments with adults. They may feel that consequences are used inconsistently or arbitrarily or receive a message that being valued and loved is conditional on their behaviour. The care and support they experience is driven by processes or tasks or are at a basic level. Support for them to maintain, re-establish or repair family and other significant relationships is lacking. People's sense of identity is compromised by poor quality information about their history, and a lack of priority or skill and creativity in engaging with them. People experience a number of moves due to caregiving families being ill prepared and ill equipped to support their needs.

Quality illustrations	
Very good	**Weak**
Where caregiver families experience difficulty, staff actively listen and involve them in planning responsive, tailored and timely interventions to support stability. People living in caregiver families benefit from a positive and enabling culture which allows them to cope with distress and frustration and resolve conflict in a safe and healthy way. Staff support caregiver families to make early and effective use of strategies for preventing escalation of harmful or challenging behaviour. People receive high quality support when they experience significant changes in their lives, including loss and bereavement.	Caregiver families are not properly supported to anticipate and prepare for key events and situations which may cause harm or distress. Contingency planning for such times is not evident increasing the likelihood of family crises or breakdowns.
Staff and caregivers understand their role in supporting people's access to healthcare and addressing health inequalities, even where the role of the service in this is minor. This includes ensuring that relevant information is shared with the right people. All people being supported by the service are as healthy as possible. They benefit from comprehensive, holistic health assessments and primary and specialist healthcare. There are a range of opportunities which promote health education, including sexual health. Where necessary and with support, they make best use of the right technology and specialist equipment. People living in caregiver families affected by disability or a long-term illness or condition, enjoy as full a life as possible. There is a continuous review of their needs.	Healthcare is disjointed. There are unmet needs, delays, or information about health needs may not be up to date at the point of moving in. This compromises the caregiver's ability to make decisions about, or to meet, these needs. Children, young people and adults have limited opportunities to develop an understanding of what contributes to a healthy lifestyle. Their right to have their views taken into account and make informed decisions about their physical, emotional and mental health and wellbeing are not respected.

Quality illustrations	
Very good	**Weak**
Caregiver families support the people they care for to be well-informed about how to lead a healthy lifestyle, including health promotion activities. They are enabled and encouraged to make informed health and lifestyle choices by adults who are positive role models. Daily routines and structures, including good sleep patterns, support their health and wellbeing. Positive mental health is a high priority for all people living within caregiver families. This might include the use of a range of credible self-help strategies for relaxation and stress-reduction. Those with additional mental health needs benefit from the support of skilled, informed and confident caregiver families and staff. They have timely access to appropriate specialist services for support in recovering from trauma, abuse and neglect. Where challenges exist, staff and caregiver families advocate persistently on their behalf. People have as much control as possible over any medication, treatments and interventions required for their wellbeing. People's lives are enhanced by being around and caring for animals. This may include having pets.	The service does not have a robust, preventive approach to children, young people and adult's mental health. Caregiver families are not supported to understand the impact of trauma on physical or mental health. A lack of access to specialist intervention or effective advocacy may compromise their health, wellbeing or recovery.
People living with caregiver families benefit from a tasty, varied and well-balanced diet that promotes their health and wellbeing and a positive body image. Mealtimes are social occasions which lead to people feeling nurtured and instil a sense of belonging. There is a proactive approach to meeting their cultural and dietary needs and preferences.	People living with caregiver families report a diet which lacks variety and balance. They may have limited choice or receive little of the food they enjoy. They do not benefit from the important social aspects of sharing food an eating together. Food practices may be insensitive and do not consider their previous experiences of food or their cultural and medical needs.

Quality illustrations	
Very good	**Weak**
Children, young people and adults play an active role in family life and are fully involved in a range of activities such as menu planning, the family shop, and preparing meals where appropriate. They acquire the necessary practical skills and knowledge for life, to look after their food and dietary needs including food safety.	

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
Discussions with: • people living in caregiver families • the manager and staff • caregiver families • child/young person/adults social worker/care manager • parents • other professionals. Observation of interactions between caregiver families and people being cared for. Review: • Records, including contact records, carer supervision records, life story work, risk assessments, reviews and evaluations • records of complaints, accidents and incidents, including restraint • relevant policies and procedures including medication	A Guide to youth justice in Scotland: Policy, practice and legislation: Section 3: Theory and methods: **http://www.cycj.org.uk/resource/youth-justice-in-scotland-guide/** Life story information **https://www.celcis.org/knowledge-bank/search-bank/blog/2021/02/how-life-story-work-can-help-care-experienced-children/** Guidance on health assessments for looked after children and young people in Scotland: **https://www.gov.scot/publications/guidance-health-assessments-looked-children-scotland/** Practice guide: suicide prevention for looked after children and young people: **https://hub.careinspectorate.com/media/1630/suicide-prevention-for-looked-after-children-and-young-people.pdf** Supporting psychological wellbeing in adults with learning disabilities and educational framework on psychological interventions: **https://www.nes.scot.nhs.uk/media/ngcha50t/ldframworkpdf.pdf**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
• carer training records on meeting the physical and emotional health needs of people and promoting healthy lifestyles • staff training records on meeting the physical and emotional health needs of people and promoting healthy lifestyles.	Transforming psychological trauma: A knowledge and skills framework for the Scottish workforce: **https://transformingpsychologicaltrauma.scot/media/x54hw43l/nationaltraumatrainingframework.pdf** National health and wellbeing outcomes: **https://www.gov.scot/publications/national-health-wellbeing-outcomes-framework/** Mental health strategy for Scotland: **https://www.gov.scot/publications/mental-health-strategy-2017-2027/** Safe administration of medication: Modules 1-3: **http://learn.sssc.uk.com/sam/** Animal Magic: The benefits of being around and caring for animals across care settings: **http://www.careinspectorate.com/images/documents/4476/Animal%20Magic_2018.pdf** Insights: Children, food and care: **https://www.iriss.org.uk/resources/insights/children-food-and-care** SCLD - Healthy eating, health living pack **https://www.scld.org.uk/healthy-eating-healthy-living-pack/** Eating well for looked after children and young people: **https://www.cwt.org.uk/publication/eating-well-for-looked-after-children-and-young-people/**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Holding Safely: A guide for residential child care practitioners and managers about restraining children and young people: https://hub.careinspectorate.com/media/1213/holding-safely-a-guide-for-residential-child-care-practitioners-and-managers.pdf Insights: trauma sensitive practice with children in care: https://www.iriss.org.uk/resources/insights/trauma-sensitive-practice-children-care Insights: Attachment-informed practice with looked after children and young people: https://www.iriss.org.uk/resources/insights/attachment-informed-practice-looked-after-children-young-people Insights: supporting positive relationships for children and young people who have experience of care: https://www.iriss.org.uk/resources/insights/supporting-positive-relationships-children-young-people-experience-care Leading for outcomes: https://www.iriss.org.uk/sites/default/files/iriss_leading_for_outcomes_a_guide_final-1.pdf

Quality Indicator 1.4: Children, young people, adults and their caregiver families get the service that is right for them

Key areas include the extent to which children, young people and adults:

- are involved in a comprehensive assessment of their holistic needs
- exercise choice in the care and support they experience
- experience high-quality care and support at all times.

Quality illustrations	
Very good	**Weak**
Caregiver families are comprehensively assessed to ensure they have the capacity to meet the needs of the children, young people and adults they are caring for. The conclusions of the assessment are evidence based and support clear recommendations with regard to the carer strengths and potential vulnerabilities. Children, young people and adult's views and choices are central to a comprehensive assessment of their needs. Staff creatively seek the views of children or adults where communication is compromised due to age or disability Decisions reflect the needs and wishes of the people involved. Staff and caregiver families understand their role and contribution to ensuring the assessment is comprehensive, even where their role is minor. Where children and young people are in need of permanent alternative care, assessments are completed without unnecessary delay. Any delays in decision making, assessments or processes are identified by the service who take proactive steps, including advocacy to address these.	The assessment and review process lacks clear conclusions or planning. Approval ranges for caregiver families are informed by the service's need for resources rather the skills and experience of the carer family. Training needs are likely to be identified from existing training provided rather than what is required. This compromises the ability of caregiver families to provide stable, nurturing care for people who need family care. Children and young people experience significant delays in planning for permanence and this is likely to significantly adversely impact on their childhood and stability.

Quality illustrations	
Very good	**Weak**
Everyone using the service has the support they need to be fully involved in reviews of the quality of care being provided and future planning. This includes any review of the caregiver family or the child, young person or adult living in the caregiver's family. Assessment and reviews always involve all key partners, including family members, carers, representatives and professionals.	
Young people and adults receive meaningful support to enable them to be full and active partners in how their choices and needs are met. They are well-informed about and understand the reasons for any decisions affecting their lives.	Decisions about young people's care and support may be service-led or based on what is already available rather than the development of suitable, individualised responses. Their changing needs and preferences are not taken into account.
People being supported by the service benefit from strong links between the service provider, commissioners and the health and social care partnership to ensure that their care and support needs are fully met. Decisions are strongly informed by the matching of the needs of the person requiring family care and the capacity of the caregiver family to meet those needs. Strengths and potential vulnerabilities are recognised and supports put in place to address these. The needs of those already living in the family are fully considered, and they experience minimal disruption as a result of someone new joining the family. Wherever possible, children, young people, and adults have sufficient time and support to visit the caregiver family prior to moving to live there.	The security and wellbeing of people living in caregiver families are compromised by poor planning around new people joining the family. These may be crises led or short notice arrangements where little thought has been given to people already living in the family. The caregiver family do not have access to the full range of information to allow them to meet people's needs. Children and young people are not empowered, encouraged or enabled to exercise their rights to choose to 'stay put' into adulthood under continuing care. They have limited access to independent advice about their options. Decisions may be based on monetary considerations rather than what is best for the individual.

Quality illustrations	
Very good	**Weak**
Children, young people and adults benefit from well-managed and positive pathways and transitions throughout their care experience. Their care and support is enhanced by creative solutions to conflicts and challenges and adapts to their changing needs and circumstances. Where relevant, they are proactively well-informed about their rights and empowered to make decisions about options for continuing care. The service ensures that young people have been involved in the development of a comprehensive welfare assessment to support their current and future needs. They are encouraged and enabled to remain in their care setting for as long as possible, and until they wish and feel ready to move on. Where relevant, people are full partners in regular reviews of their care and support In addition to high-quality practical and emotional support when they have left care, children and young people benefit from the continuity of relationships with people who matter to them. If children and young people will eventually require the support of adult services, the process of consultation, assessment and planning begins well in advance. There is a strongly collaborative approach between children's and adults' services, in which they are fully involved at all stages. The transition is implemented at a pace that suits them and reflects best practice.	When they leave their care setting, young people experience unnecessary disruption in their lives and in key relationships. They may be unprepared or lacking in the support they need to sustain them at this critical time. The consequences may be life-limiting and lifelong.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
Discussions with: • people living in caregiver families • the manager and staff • caregiver families • child/young person/adults social worker/care manager • parents • other professionals. Observation of interactions between caregiver families and people being cared for. Review: • people's records including assessment reports, panel minutes, contact records, carer supervision records, risk assessments, reviews and evaluations. • welcome and introductory information for caregiver families and people living with caregiver families. • relevant policies and procedures including referrals and admissions.	Staying put Scotland: Providing care Leavers with connectedness and belonging: **https://www.gov.scot/publications/staying-put-scotland-providing-care-leavers-connectness-belonging/** Children and Young People (Scotland) Act (2014): Guidance on Part 11: Continuing Care: **https://www.gov.scot/publications/guidance-part-11-continuing-care-children-young-people-scotland-act/** Continuing care and welfare assessments: Practice Note: **https://www.celcis.org/files/7116/0569/2849/Continuing_Care_and_Welfare_Assess_-_Practice_Note_FINAL_proofed.pdf** Children and Young People (Scotland) Act (2014): Guidance on Part 10: Aftercare: **https://hub.careinspectorate.com/media/1136/children-and-young-people-scotland-act-2014-guidance-on-part-10-aftercare.pdf** Throughcare legislation and guidance: **https://www.gov.scot/publications/supporting-young-people-leaving-care-scotland-regulations-guidance-services-young/** Permanence and care excellence (PACE) resources: **https://www.celcis.org/our-work/key-areas/permanence/pace-homepage** Permanently progressing research: **https://www.stir.ac.uk/about/faculties/social-sciences/our-research/research-areas/centre-for-child-wellbeing-and-protection/research/permanently-progressing/**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	The Scottish care leavers covenant: https://www.staf.scot/scottish-care-leavers-covenant Continuing care and co: Conversation openers: https://www.iriss.org.uk/sites/default/files/2018-04/continuing-care-co-web.pdf Inform: The Children and Young People (Scotland) Act 2014: Parts 10 and 11 (Aftercare and Continuing Care): https://www.celcis.org/files/9114/3878/4824/Inform__Children_Young_People_Act_Part_10-11.pdf Getting it right for looked after children and young people: https://www.gov.scot/publications/getting-right-looked-children-young-people-strategy/pages/1/ Practice guide to chronologies: https://www.careinspectorate.com/images/documents/3670/Practice%20guide%20to%20chronologies%202017.pdf Principles of good transitions 3 - including the autism and life shortening conditions supplements: https://scottishtransitions.org.uk/7-principles-of-good-transitions/ Understanding personal outcomes: https://www.sssc.uk.com/supporting-the-workforce/self-directed-support-and-integration/personal-outcomes/

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Supported decision making: https://www.mwcscot.org.uk/sites/default/files/2021-02/Supported%20Decision%20Making%202021.pdf Assessment of prospective carers and permanence planning during COVID-19: https://www.celcis.org/knowledge-bank/search-bank/assessment-prospective-kinship-foster-and-adoptive-carers-progress-permanence-planning-during-covid-19-lockdown/

Key Question 2:
How good is our leadership?

This key question has four quality indicators associated with it. They are:

2.1 Vision and values positively inform practice.
2.2 Quality assurance and improvement is led well.
2.3 Leaders collaborate to support children, young people, adults and their caregiver families.
2.4 Staff are led well.

Quality Indicator 2.1: Vision and values positively inform practice

Key areas include the extent to which:

- vision, values, aims and objectives are clear and inform practice
- innovation is supported
- leaders lead by example and role model positive behaviour.

Quality illustrations	
Very good	**Weak**
The vision, aims and values are clear, understood by all, fully implemented and embedded in the culture of the service. They are inspiring, inclusive and embrace equality. Leaders are ambitious in actively seeking to achieve the best possible outcomes for people using the service. Any review of the service aims and objectives is strongly influenced by the voices of those who use and work in services. For example, care experienced ambassadors, mentors or champions. This is central to the way in which care and support is provided and experienced.	The vision for the service lacks clarity or collective ownership and does not focus sufficiently on improving outcomes. An inclusive, rights-led and personal outcomes approach is not fully embedded in the culture and systems of practice. Staff have limited awareness of the service's ethos, values and aims.
The culture encourages and supports creative contributions from people using the service, staff and other stakeholders. Care and support is person-centred and fosters a culture of positive and informed risk-taking. Leaders and staff respect human rights and embrace the service's vision, values and aims to ensure these are met.	Where improvements are needed, there is limited strategic or innovative thinking. The management culture is focused on organisational goals, which are prioritised over the needs of people using the service. Staff do not feel confident about making suggestions or implementing improvements. They do not adapt practice and tailor care and support in order to meet people's needs and wishes.

Quality illustrations	
Very good	**Weak**
Leaders ensure that the culture is supportive, inclusive and respectful, confidently steering the service through challenges. They are visible role models and guide the service's strategic direction and the pace of change. Leadership is shared to support creative approaches to problem solving, effective policy implementation and to support stability during times of change and staff turnover.	Leadership is weak or lacks stability, energy or effectiveness. Shared leadership is not in evidence. There may be a blame culture. Leaders may not be sufficiently well known to either people being supported by the service or staff.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
Discussions with: • people using the service • managers and staff • parents and carers • stakeholders. Observation of staff practice and interactions. Review: • statement of aims and objectives/ vision • participation records • risk assessments • evidence of resilient leadership to account for staff absence or staff turnover (deputising/management team/shared leadership.	Step into leadership: **https://www.stepintoleadership.info/** Insights: achieving effective supervision: **https://www.iriss.org.uk/resources/insights/achieving-effective-supervision** Supervision learning resource: **https://www.stepintoleadership.info/index.html** Guidance for providers on aims and objectives: **https://www.careinspectorate.com/images/Guidance_for_providers_and_applicants_on_aims_and_objectives.pdf**

Quality Indicator 2.2: Quality assurance and improvement are led well

Key areas include the extent to which:

- quality assurance, including self-evaluation and improvement planning, drives change and improvement
- leaders are responsive to feedback and use learning to improve
- leaders have the skills and capacity to oversee improvement.

Quality illustrations	
Very good	**Weak**
There is continuous, robust evaluation of people's outcomes and experiences to ensure they receive the best possible care and support. Quality assurance also leads to improved inputs and processes for delivering the service. People's views are central to the process of evaluation and they are well-informed about any changes. Leaders empower others to become involved in comprehensive quality assurance systems and activities. This leads to the development of a dynamic improvement plan which is continuously evaluated and successfully drives the future direction of the service. This process is well-managed, with research and best practice used to benchmark measurable outcomes. There are robust, transparent, safe and effective approval processes in place for applicants who wish to become caregiver families. Where services must or choose to have a panel as part of this process, the panel are appropriately skilled and experienced.	There are some systems in place to monitor aspects of service delivery and their impact on how people experience the service, however, these may be disorganised or haphazard and fail to provide an assurance of quality within the service. There is a lack of clarity about roles and responsibilities. Quality assurance processes, including self-evaluation and improvement plans, are largely ineffective. The approaches used do not allow accurate assessment of performance or have effective review arrangements to assess the likely impact of any planned improvements. Staff and people's contribution to quality assurance is minimal or peripheral. They have limited awareness of the methods used or the intended outcomes.

Quality illustrations	
Very good	**Weak**
They provide good quality, professional advice, guidance and challenge to the service in relation to how people experience the service and decision making. The agency decision maker role is well defined and provides a clear overview of decision making.	There is a lack of external oversight to support good quality practice and outcomes. People being supported by the service may not know what the external oversight arrangements are or rarely have opportunities to share their views at that level. External leaders' lack of contact with and knowledge about the service make them less effective in providing additional safeguards and assurance. Approval processes for new care giver families lack the necessary transparency to ensure that decision making is appropriate and well recorded. Panel members and the agency decision maker may lack the appropriate skills and experience to fulfil their responsibilities effectively.
People being supported by the service are well-informed about the standards they should expect from the service. There is a culture of learning within the service which genuinely values the voices of people being supported. People who use the service feel empowered to give feedback and raise concerns. They know their views are valued, inform future planning and will be acted on promptly without negative consequences. Where things go wrong with a person's care and support, or their human rights are not respected, leaders learn from this and offer a genuine apology. Reflecting on complaints, concerns and significant events is fully embedded in the service and leads to improvement.	Leaders fail to motivate staff and others to contribute to positive change. Lack of information regarding the rationale for improvement may inhibit change. Changes may happen as the result of crisis management rather than through robust quality assurance. People are not encouraged to have high expectations of their care and support, are unsure how to raise concerns, or do not feel supported to do so. If complaints and concerns are upheld, or mistakes are made, there is limited learning to drive sustained and meaningful change.

Quality illustrations	
Very good	**Weak**
Leaders know what is working well and what needs to improve. They communicate this effectively to staff and to people using the service. They ensure that the needs and wishes of people being supported by the service are the primary drivers for change. Leaders at all levels successfully direct and support improvement activities and are confident about where to obtain support and guidance. The pace of change reflects the improvements needed. The inclusive culture and enabling leadership of the service allows caregiver families and staff to nurture relationships with the people they care for.	There is insufficient capacity to support improvement activities effectively or to embed change. The pace of change may be too slow or is unsustainable.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
Discussions with: • people who use the service • parents and carers • managers and staff • stakeholders. Review: • quality assurance records • self-evaluation records and improvement plan • records of complaints and incidents • feedback from people who use the service	The model for improvement and associated resources: **http://hub.careinspectorate.com/improvement/** Organisational duty of candour: **https://www.gov.scot/publications/organisational-duty-candour-guidance/** National occupational standards (NOS): **https://learn.sssc.uk.com/nos/index.html** EFQM Excellence model: **https://www.efqm.org/index.php/efqm-model/** Learning from adverse events through reporting and review. A national framework for Scotland 2019: **http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/national_framework.aspx** Fostering and adoption legislation and guidance: **The Looked After Children (Scotland) Regulations 2009 (legislation.gov.uk)** **Adoption and Children (Scotland) Act 2007 (legislation.gov.uk)** **Guidance on Looked After Children (Scotland) Regulations 2009 and the Adoption and Children (Scotland) Act 2007 - gov.scot (www.gov.scot)** Notifications about controlled drugs: Guidance for providers: **https://hub.careinspectorate.com/media/1566/notifications-about-controlled-drugs-guidance-for-providers.pdf**

Quality Indicator 2.3: Leaders collaborate to support children, young people, adults and their caregiver families

Key areas include the extent to which:

- leaders understand the roles and responsibilities of other partners
- services work in partnership with others to secure the best outcomes for everyone being supported by the service
- leaders oversee effective transitions for children, young people and adults.
- leaders have the skills and capacity to oversee improvement.

Quality illustrations	
Very good	**Weak**
Leaders overcome barriers to enable people using services to be the central focus of decision making. A culture of joint responsibility and effective information sharing creates a positive climate for decision making. This takes into account each person's whole life including their physical, mental, cultural and emotional and spiritual needs. Because leaders have a sound knowledge of the key roles and responsibilities of partner agencies, they quickly identify when to involve them. Partner or multi-agency working is supported by a clear strategy to facilitate working together so that people get the right support when they need it. Leaders recognise the benefits of sharing ideas and successes both within the service and further afield. Leaders ensure that services are delivered efficiently and effectively. They monitor the effectiveness of joint work with other providers and agencies.	Leaders lack understanding of how people may benefit from the involvement of external organisations. They do not ensure that care and support is provided collaboratively. There is an absence of strategy and guidance to inform this approach. Leaders lack the knowledge, skills and confidence to access and harness additional or specialist support and expertise.

Quality illustrations	
Very good	**Weak**
Where people are supported by more than one organisation, they benefit from all of them working together effectively. This includes sharing information appropriately and coordinating care and support so that they experience consistency and continuity. Where information is being shared between agencies for specific purposes, consent is obtained, except where to do so is likely to cause harm.	Communication with partners is ineffective. Progress is constrained by leaders being unclear about the principles of consent and information sharing. Leaders do not implement learning from other organisations to influence and improve the services they provide.
Leaders ensure that commissioned services are delivered efficiently and effectively. They will monitor the success and suitability of living situations to ensure that that caregiver families can meet the needs of children, young people and adults. When people are moving on, leaders contribute to the clear processes that support the person with this. The culture, knowledge and experience of people within the service ensure that planning and decision making is effective, involves all relevant people and supports positive destinations.	There are no, or poorly managed, commissioning arrangements in place meaning that positive outcomes for people are compromised. Transition processes are experienced as disconnected and complex. For young people this might mean they are constrained in their ability to move on to adulthood by difficulties in accessing suitable services such as mental health and wellbeing services and housing options. This results in uncertainty or distress.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
Discussions with: • people using the service • parents and carers • managers and staff • stakeholders. Observation of staff and carer practice and interactions. Review: • children and young people's records for evidence of inter-agency working • information sharing policy and practice.	Step into leadership: **http://www.stepintoleadership.info** General Data Protection Regulation (GDPR) guidance: **https://www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation** Partnerships and co – conversation openers: **https://www.iriss.org.uk/resources/tools/partnerships-co**

Quality Indicator 2.4: Staff are led well

Key areas include the extent to which:

- leaders at all levels make effective decisions about staff and resources
- leaders at all levels empower staff to support children, young people, adults and their caregiver families
- leadership has a positive impact on staff.

Quality illustrations	
Very good	**Weak**
Leaders engage meaningfully with staff, people being supported by the service, their families and others, taking a collaborative approach to planning and delivering care and support. They are skilled at identifying and delivering what is needed to provide the best care, support and protection. They understand any limitations the service may have.	Leaders do not anticipate the type and level of resources needed for people or identify potential barriers. This has a detrimental impact and fails to prevent difficulties arising or escalating. There is a lack of vision and creativity in identifying resources or interventions which meet the unique needs of each individual.
Leaders model a team approach, encouraging and appreciating the contributions and expertise of others. They provide a working environment where people are encouraged to curiously question, supportively challenge and critically reflect on their own and other's practice. This approach promotes a supportive, learning culture which recognising that people are often experts in identifying their own needs. Leaders ensure equality of opportunity both among staff and for people supported by the service. They use successes as catalysts for further improvement in the quality of each individual's outcomes and experiences.	Staff are not empowered to help identify solutions for the benefit of people being supported by the service. Leaders do not always engage staff, leading to confusion and a lack of clarity of roles and responsibilities. The service may have a culture of blame. Communication and direction are lacking, and the steps required to make improvements are not sufficiently detailed. The rationale for change is not always clear to staff, and this has a negative impact people's experience. Equality and inclusion are not embedded within policies, procedures and plans. There is a lack of understanding of staff and caregiver's role in delivering high quality care and support.

Quality illustrations	
Very good	**Weak**
Leaders are aware of the need to be flexible and adapt their leadership style to help motivate staff to deliver high quality care and support. They promote a good work-life balance which has a positive impact on both staff and people being supported by the service.	Opportunities for staff to use their initiative, take responsibility and influence change are limited. They seldom adopt leadership roles. The extent to which professional learning is linked to organisational priorities is limited. Staff may work in isolation rather than as part of a team with shared responsibilities.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
Discussions with: • people using the service • parents and carers • managers and staff • stakeholders. Review: • service improvement plan • quality assurance policy, procedure, practice and outcomes • staff learning and development records • staff supervision and appraisal records.	Step into leadership: **http://www.stepintoleadership.info/** Leadership development activities: **http://23leadership.sssc.uk.com/** Everyday leadership from the frontline: **https://www.iriss.org.uk/news/news/2019/09/11/everyday-leadership-frontline** Guidance on development of policy and procedure: **https://hub.careinspectorate.com/media/1530/health-related-policy-and-procedure-template-policy-for-all-services.pdf**

Key question 3:
How good is our staff team?

This key question has three quality indicators associated with it. They are:

3.1 Staff have been recruited well.
3.2 Staff have the right knowledge, competence and development to support children, young people, adults and their caregiver families.
3.3 Staffing arrangements are right and staff work well together.

We are considering staff employed by the service. This does not include carers or panel members. Carer recruitment is under 1.4. Panel member recruitment is under 2.2

Quality indicator 3.1: Staff have been recruited well

Key factors include the extent to which staff:

- the service implements safer recruitment principles and practice
- recruitment and induction is tailored to reflect outcomes for children, young people, adults and their caregiver families
- induction is tailored to the training needs and roles and responsibilities of individual staff member.

Quality illustrations	
Very good	**Weak**
Recruitment and selection is informed by national guidance and best practice. There is a strong emphasis on values-based recruitment. High quality recruitment information including contractual agreements ensure that candidates are fully aware of the conduct, capabilities and qualities that are required of them. The process is well organised and documented so that core elements of the procedure are followed consistently. Staff are appointed and start work only after all pre-employment checks have been concluded. People being supported by the service have opportunities and the necessary support to be actively involved in recruitment and selection. This is done in a meaningful and appropriate way which takes their expertise and views into account.	There is insufficient understanding of the principles and practices of safer recruitment and the part they play in preventing unsuitable people from entering the workforce. This may lead to key elements of the process not being fully implemented, even when good quality recruitment policies are in place. Recruitment and selection is not informed or enhanced by people's views and active involvement.

Quality illustrations	
Very good	**Weak**
The values of staff recruited are compatible with the service's aims and objectives. The skills, knowledge and values of the staff being recruited reflect the needs of the people being supported by the service.	The values and motivation of potential staff may not have been explored as part of the recruitment process and may not inform recruitment decisions. The service may not fully understand the essential characteristics required by staff. New staff may therefore not have the appropriate attitudes and values or the potential to gain the necessary knowledge and skills to support high quality outcomes.
All staff take part in a comprehensive, well planned induction that has been developed to ensure they are able to perform their work to a high standard. This includes significant emphasis on implementing the Health and Social Care Standards, Independent Care Review, legislation and good practice. The pace and length of induction ensures that staff become familiar with expectations and demonstrate competence in all key areas. Throughout the recruitment process, individual learning needs and styles are taken into account. There is likely to be a range of learning styles, for example the opportunity for face-to-face discussion and shadowing of more experienced staff.	Induction provides limited opportunities for genuine learning. There is no expectation that staff will perform to a required standard and demonstrate potential for continuous development. Induction policies, procedures, guidelines and structures of support do not provide an adequate framework for new staff to develop confidence in their new role. There may be a lack of clarity about their role or the provider's responsibilities for promoting their development. Formal supervision is limited and there is no shared understanding of next steps. The induction may be generic, have not been reviewed recently, or may not include effective input about the Health and Social Care Standards.

Quality illustrations	
Very good	**Weak**
Staff are clear about their roles and responsibilities and conditions of employment. They have written information to which they can refer and a named member of staff for support. There is additional supervision during the induction and probationary period. This allows them to receive the necessary opportunities to discuss learning needs or other issues. People who are supported by the service are enabled to contribute their views to the evaluation of staff performance during the induction phase.	

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
Discussions with: • people being supported by the service • the manager and staff (including new staff) • parents and carers • other professionals. Review: • recruitment and induction policy and procedure • recruitment and selection and induction records • analysis of staff skills • staff turnover information and action plan.	Safer recruitment through better recruitment: **https://hub.careinspectorate.com/media/1608/safer-recruitment-through-better-recruitment.pdf** The national health and social care workforce plan: **https://www.gov.scot/publications/national-health-social-care-workforce-plan-part-2-framework-improving/** Independent Care Review: **https://www.carereview.scot/wp-content/uploads/2020/02/The-Promise.pdf**

Quality indicator 3.2: Staff have the right knowledge, competence and development to support children, young people, adults and their caregiver families

Key factors include the extent to which staff:

- staff competence and practice lead to improving outcomes for children, young people, adults and their caregiver families
- staff learning and development lead to improving outcomes for children, young people, adults and their caregiver families
- staff practice is supported and improved through effective support, supervision and appraisal.

Quality illustrations	
Very good	**Weak**
Staff practice strongly reflects the values and principles of the Health and Social Standards and relevant professional codes. Staff consistently form enduring, trusting and genuine relationships with people being supported by the service. They use their authority appropriately and are highly skilled in supporting caregiver families to manage challenging situations such as resolving conflict. The workforce is trusted and expected to use their values and professional judgement to enable appropriate caring and loving relationships. Staff are empowered and equipped to deliver the best quality practical and emotional care and support. Their competence is regularly assessed to ensure that learning and development strategies support the highest quality outcomes and experiences.	Staff may be registered with relevant professional bodies but do not fully understand their responsibilities for continuous professional development or how they can fulfil this. They may lack confidence or support in taking responsibility for their own learning and development. Staff adopt an overly procedural approach to their work, which is not based on relationships and values. They may have limited understanding of the symptoms of trauma or the impact of adversity on people's life experiences. Arrangements for assessing staff practice are under-developed. There is limited support for staff to reflect or for identifying and meeting learning needs.

Quality illustrations	
Very good	**Weak**
There is a strong culture of reflection and learning in the service. Staff have high quality learning opportunities based on research evidence and good practice. These are regularly evaluated to meet changing needs. The needs of people being supported by the service influence staff development and training and they may be directly involved in its delivery. There is a range of approaches to learning, including the opportunity for group and face-to-face training, staff coaching, mentoring and peer review. A clear structure of training and learning and development is in place for each staff role and all staff have individual plans. They consistently implement their learning to provide high quality care and support.	Continuous learning has a low priority in the service. There is limited access to best practice and research or opportunities to ensure knowledge is consolidated and embedded into practice. Learning opportunities lack breadth and scope, with little reference to values and codes. There is no effective training analysis for the service or individual staff. This means the plan for training is static and may not reflect people's needs. Staff do not take sufficient responsibility for their own learning and development or for reporting misconduct or unsafe working practices. They have few opportunities for exercising autonomy, using their initiative or developing leadership skills.
Staff benefit from a framework of support which reflects the demanding nature of their work and promotes high quality, sensitive care and support. Regular, high quality supervision and appraisal are used constructively by staff. These contribute to their professional development and enable them to become competent, confident and reflective practitioners. Supervision and appraisal inform the development of the service's staff skills analysis and training plan.	Insufficient attention is paid to staff self-care and support. As a result, they may regularly experience stress, or their ability to manage setbacks and challenges and promote attuned care and support is compromised. Supervision takes place infrequently or is given insufficient priority as a key element of a staff support and development framework. It is limited in its breadth and scope and provides few opportunities for reflection. Supervisors and staff are unclear about the purpose and principles of professional supervision. Records do not reflect discussion and decision-making. .

Quality illustrations	
Very good	**Weak**
The views of children, young people, adults and their caregiver families inform and enhance the quality of supervision and appraisal.	Systems for identifying and meeting learning needs are not robust enough and result in gaps remaining unfilled. The potential for children, young people, adults and their caregiver families to contribute their views to the staff support and development process is not recognised.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
Discussions with: • caregiver families, children, young people and adults • the manager and staff • parents and carers • visitors • other professionals. Review: • training analysis, plans and records • records of observation of staff practice • records of supervision and appraisal • disciplinary records • staff support/learning and development policies and procedures • system for monitoring staff registration.	Codes of practice for social service workers and employers: **https://www.sssc.uk.com/the-scottish-social-services-council/sssc-codes-of-practice/** The framework for continuous learning in social services: **https://lms.learn.sssc.uk.com/pluginfile.php/64/mod_resource/content/1/clf.pdf** Common core skills and national occcupational standards: **http://learningzone.workforcesolutions.sssc.uk.com/course/view.php?id=83** Insights: achieving effective supervision: **https://www.iriss.org.uk/resources/insights/achieving-effective-supervision** Supervision learning resource: **http://www.stepintoleadership.info/assets/pdf/SSSC-Supervision-learning-resource-Sept-16.pdf** SSSC open badges: **https://www.badges.sssc.uk.com/**

Quality indicator 3.3: Staffing arrangements are right and staff work well together

Key factors include the extent to which staff:

- there is an effective process for assessing how many staff or staff hours are needed
- the skill mix, numbers and deployment of staff meet everyone's needs
- staff are flexible and support each other to work as a team to benefit children, young people, adults and their caregiver families.

Quality illustrations	
Very good	**Weak**
A process of assessment determines the numbers, experience, qualifications and skill mix of staff required within the service to promote positive outcomes. It takes into account the level of workload, the complexity of the task, the recruitment of caregiver families, the overseeing and delivery of learning and development for caregiver families, and a range of other factors.	The number of staff or staff hours being deployed does not reflect changing needs within the service. There is an over-reliance on agency or sessional staff, or caseloads are continually changing between staff. This leads to people being supported by the service experiencing a lack of consistency and stability in how their support is provided and limits their ability to build trusting relationships with staff.
Staff have time to provide care and support with compassion, and to spend meaningful time with individual families. Staff are clear about their roles and are deployed effectively. They help each other by being flexible in response to changing situations to ensure care and support is consistent and stable.	There is a minimal number of staff at any one time and this is sometimes insufficient to fully meet diverse needs. Staff frequently work excessive hours or under pressure, leading to some aspects of support being neglected, with negative outcomes. Families perceive staff to be too busy to provide effective support and some activities such as support groups may be cancelled.

Quality illustrations	
Very good	**Weak**
Families being supported and staff benefit from a warm atmosphere created by good working relationships, support and mutual respect. There is effective communication between staff, with opportunities to discuss and reflect on their work and how best to improve outcomes for people using the service. High levels of motivation and good team working mean that families experience a team approach to support and feel they can speak to anyone in the team for support or advice. Staff resilience helps to support and guide caregiver families through times of change. There is recognition of the important role played by staff who are not involved in providing direct care for families, for example administration staff. They are empowered to contribute to the overall support available to families and to build positive relationships with them.	Pressure on staff leads to an over-emphasis on completing designated tasks without regard for the wider needs of either people being supported by the service or colleagues. Care and support is at a basic or superficial level, with little time for meaningful communication and support. Communication and team building may suffer due to lack of time and affect staff motivation and morale. This has a negative impact on families.
There is proactive use of a range of methods for retaining skilled and experienced staff so that families benefit from stable, enduring relationships.	There is a lack of understanding of attachment and the importance of continuity of relationships for people. The service does not use targeted actions to address high turnover, based on accurate data and analysis.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
Discussions with: • caregiver families, children, young people and adults • the manager and staff • parents and carers • visitors • other professionals. Observe staff practice and interaction as a staff team. Review assessments of staffing levels (workload capacity).	Records that all registered care services (except childminding) must keep and guidance on notification reporting: **https://www.careinspectorate.com/images/documents/2611/Rcds%20services(except%20cm)%20must%20keep%20and%20guidance%20on%20notification%20reporting%20(300420).pdf** Workforce information: **https://hub.careinspectorate.com/national-policy-and-legislation/policies/workforce/**

Key question 4: How good is our setting?

Currently not assessed for this service type.

Key question 5: How well is our care and support planned?

This key question has two quality indicators:

5.1 Assessment and care planning reflects the outcomes and wishes of children, young people and adults.
5.2 Parents, carers and family members are involved.

Legislation does not require fostering or adoption services to produce personal plans for children, young people or caregiver families. Planning referred to in this section relates to a range of planning processes including:

Fostering

- Fostering agreements (SSI 2009/210)
- Fostering placement agreements (SSI 2009/210)
- Pathway plans
- Welfare assessments
- The child's plan

Adoption

- Adoption support plans
- Coordination meetings

Adult placement services

- Carer agreements
- Placement agreements
- Personal plans

Quality indicator 5.1: Assessment and care planning reflects the outcomes and wishes of children, young people and adults.

Key factors include the extent to which staff:

For all services

- children, young people and adults are involved in directing and leading their own care and support
- all plans are reviewed and updated regularly, and as circumstances, needs and desired outcomes change.

For fostering services

- the fostering service actively seeks involvement in multi agency planning for children and young people.

For adoption services

- the adoption service proactively plans the need for post adoption support services for families.

For adult placement service

- the adult placement service uses personal plans to deliver care and support effectively.

Quality illustrations	
Very good	**Weak**
For all services: People lead positive, heathy enjoyable and meaningful lives through the implementation of high quality, SMART planning. People are at the heart of planning for their care and support. They are enabled to lead and direct their development so they feel a real sense of ownership and can clearly recognise their own voice.	For all services: People have limited involvement in the care and support planning and review process. This means they do not consistently experience care and support in line with their wishes and preferences. When plans conflict with their wishes, there is no clear legal justification, they do not receive a proper explanation and the service fail to advocate on their behalf.

Quality illustrations	
Very good	**Weak**
For all services: They receive full support to communicate what their outcomes should be, including advocacy where required. Planning is clearly understood by all involved. Where people are not able to fully express their wishes and preferences, individuals who are important to them, or who have legal authority, are involved in shaping and directing planning. Where planning is the responsibility of other agencies, such as the child's plan for children and young people using fostering services, the service strongly advocates for and supports the involvement of people being cared for and their caregiver family. The service challenges situations where people they support are not involved in planning.	For all services: Plans and reviews are not routinely made available or provided in an accessible format to children, young people, adults and their representatives.
For all services: People benefit from planning that is regularly reviewed, evaluated and updated involving relevant professionals. including independent advocacy, and take account of good practice and their own individual preferences and wishes. There is a range of methods used to ensure that people are able to lead and direct the development and review of their plans in a meaningful way.	For all services: Multi-disciplinary professional involvement in the care planning and review process may be limited. People may not benefit from professional advice because this is not taken account of in the planning and review process. Plans do not reflect up-to-date good practice guidance. Care reviews may not be carried out in line with legislation. Where people are supported in crisis, staff are unable to respond flexibly when they identify what is and is not working for the person.

Quality illustrations	
Very good	**Weak**
For fostering: Very good outcomes are supported by high quality multi-agency planning and individualised safer caring approaches. These are underpinned by a robust assessment of need and risk. People benefit from a dynamic and aspirational approach which consistently informs all aspects of care and support. The service actively seeks and supports multi-agency involvement in the planning process and takes appropriate steps to ensure that all children, young people and their caregiver families have appropriate plans in place. Children and young people's records are of a consistently high standard and are informed by rights, values, principles and codes of practice.	For fostering: Children and young people's wellbeing is compromised by admissions that are inadequately planned. Staff and caregiver families do not have access to the relevant information to allow them to meet their needs. The standard of assessment or planning is weak, with insufficient attention to children, young people's needs, strengths and potential. The quality of their outcomes and experiences may be limited by the low expectations of those involved in planning or plans may be out of date. Leaders do not maintain oversight of the assessment and planning process, and there is a lack of effective quality assurance. Plans are static documents rather than tools to inform care giver families of approaches to care and support. They may not reflect the care and support provided, experienced, or needed by children, young people adults or their caregiver families.

Quality illustrations	
Very good	**Weak**
For adoption: Very good outcomes for families are supported by high quality multi-agency and individualised adoption support planning. This identifies the need for current and future supports which might be needed at different times. These are underpinned by a robust assessment of need and risk. Adoption support plans are of a consistently high standard and are informed by rights, values, principles and codes of practice. People benefit from available current and future support, which is responsive, timely and creative. This recognises the need to support families to nurture children throughout their lives and overcome the difficulties that get in the way.	For adoption: Family stability is compromised by poor quality coordination and planning. Practical and emotional support needs are not available or inadequately anticipated or planned. Poor information exchange means families lack the ability to fully meet their children's needs. The standard of assessment or planning is weak, with insufficient attention paid to the family's strengths and vulnerabilities. Leaders do not maintain oversight of the assessment and planning process, and there is a lack of effective quality assurance. Plans are static documents rather than tools to inform staff practice and approaches to care and support. They may not reflect the care and support provided, experienced or needed by families.
For adult placement: Very good outcomes for families are supported by high quality care and support planning. People, and where relevant, their families are fully involved in developing their personal plans. Strong leadership, staff competence, meaningful involvement and embedded quality assurance and improvement processes support this happening. Care and support planning maximise people's capacity and ability to make choices. This includes the potential for people to reduce the support they receive and to maximise independence.	For adult placement: Personal plans are basic or static documents and are not routinely used to inform staff practice and approaches to care and support. People may not know whether they have a personal plan, or it may be in a format that is not meaningful to them. The standard of care and support planning is inconsistent and is not supported by the strong leadership, staff competence and quality assurance processes. Personal plans focus entirely on people's needs or a deficit led approach rather than on building an enabling approach based on assets or outcomes.

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
Speak to people being supported by the service: • family members • visitors • staff • managers and other professionals. Review people's assessments and planning including (where appropriate): • child's plan and reviews • welfare assessments and reviews • pathway plans and reviews • adoption support plans and reviews • adoption coordination planning • personal plans and reviews. • foster care agreements • placement agreements	Public Services Reform (Scotland) Act 2010, asp 8: **https://www.legislation.gov.uk/sdsi/2013/9780111020234** Mental Welfare Commission guidance on: • personal plans • advance statements • power of attorney • supported decision making **https://www.mwcscot.org.uk/publications?type=39** Scottish Independent Advocacy Alliance – companion guides: **https://www.siaa.org.uk/publications-category/companionguide/** Think local act personal – personalised care and support planning tool: **https://www.thinklocalactpersonal.org.uk/Latest/Making-it-Real-how-to-do-personalised-care-and-support/** Children and Young People (Scotland) Act 2014, asp 8: **https://www.legislation.gov.uk/asp/2014/8/contents/enacted** The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 2011/210: **http://www.legislation.gov.uk/ssi/2011/210/pdfs/ssi_20110210_en.pdf** A guide to youth justice in Scotland: Policy, practice and legislation (section 3: Theory and methods): **https://www.cycj.org.uk/resource/youth-justice-in-scotland-guide/**

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
	Leading for outcomes: children and young people: https://www.iriss.org.uk/sites/default/files/iriss_leading_for_outcomes_a_guide_final-1.pdf Personal outcomes approaches: https://personaloutcomes.network/ Person-centred support planning information: http://helensandersonassociates.co.uk/person-centred-practice/care-support-planning/ Continuing care and the welfare assessment: practice note: https://www.celcis.org/files/7116/0569/2849/Continuing_Care_and_Welfare_Assess_-_Practice_Note_FINAL_proofed.pdf Throughcare legislation and guidance: https://www.gov.scot/publications/supporting-young-people-leaving-care-scotland-regulations-guidance-services-young/

Quality indicator 5.2: Parents, carers and family members are involved

Key factors include the extent to which staff:

- parents, carers and family members are involved in delivering care and support
- the views of parents, carers and family members are heard and meaningfully considered.

Quality illustrations	
Very good	**Weak**
The service is proactive in gaining the views of parents, guardians, previous carer families and family members where appropriate. Their views and wishes strongly inform the individual assessment, planning and review process, even where this challenges previous approaches. Where they have additional communication needs, or English is not a first language, they have ready access to the right services and tools to ensure they are fully included.	Parents, guardians, previous carers and family members may feel overlooked or are not given enough encouragement and support to make their views known or contribute to decision-making. The quality of assessments, plans and evaluation may be compromised because insufficient weight is given to their knowledge about what is or is not likely to work for people being cared for.
Where relevant, there is a supportive and inclusive approach to working in partnership with parents, guardians, carers and family members in the delivery of care and support. They make suggestions, comments or complaints, knowing that these are always listened to and acted on in an honest and transparent way. Leaders and staff always sensitively manage any conflicts between children, young people, adults and their caregiver families and family members' and guardians' views and wishes. This shows due regard for consent and other legal considerations.	Leaders and staff either seldom engage with people's families or fail to do so in a meaningful way. There are limited ways for parents, guardians, carers and family members to be actively involved. Changes to how care and support is provided are rarely made as a result of their involvement. Leaders and staff are not well-informed about who has parental responsibility or other legal powers such as guardianship or power of attorney arrangements and may fail to fulfil their legal obligations in relation to information sharing and consent.

Quality illustrations	
Very good	**Weak**
At all times, high expectations, aspirations and the best interests of children, young people, adults and their caregiver families are at the forefront of the way care and support is delivered.	

Scrutiny and improvement toolbox	
Scrutiny and improvement support actions	**Key improvement resources**
Speak with: • people • family members • visitors • staff • managers and other professionals. Review assessments, personal plans and reviews. Observe staff working with parents, carers and family members.	Parental rights and responsibilities under Children (Scotland) Act 1995: **https://www.legislation.gov.uk/ukpga/1995/36/contents** Carers Act: **http://www.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation/Carers-scotland-act-2016** Equal partners in care: **http://www.ssks.org.uk/equalpartnersincare** Carers Trust: Triangle of care, carers included: **https://carers.org/downloads/resources-pdfs/triangle-of-care-england/the-triangle-of-care-dementia-england.pdf** Scottish Social Services Council guidance: **www.sssc.uk.com** Mental Welfare Commission – Carers and confidentiality good practice guide. **https://www.mwcscot.org.uk/publications/good-practice-guides/**

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LGBT CHARTER FOUNDATIONS

Moray Fostering Service
Fostering Service

The Moray Council
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Telephone: 01343 563 552

Type of inspection:
Announced (short notice)

Completed on:
6 July 2023

Service provided by:
The Moray Council

Service provider number:
SP2003001892

Service no:
CS2004082074

About the service

Moray Fostering service provides a fostering service for children and young people who are unable to live at home.

The service recruits and supports foster carers who provide care to children in need of alternative care.

Inspections of an adult placement (continuing care service) and adoption service have been undertaken and separate reports have been completed.

About the inspection

This was a short notice inspection which took place between 19 June 2023 and 6 July 2023. The inspection was carried out by two inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with seven people using the service and six young people
- spoke with ten staff and management
- observed practice and daily life
- reviewed documents
- spoke with visiting professionals.

Key messages

- Children and young people experienced supportive, enduring relationships with fostering families that provided them with a sense of belonging.
- Children were supported to maintain meaningful relationships with extended family members and were involved in the wider community.
- Children and young people required further support to maintain meaningful contact with siblings.
- Outcomes for children and young people could be improved by further strengthening the matching process to ensure that this process fully considers the needs of existing children in the fostering family.
- Caregivers valued relationships with their social workers, and we assessed that staff were skilled at supporting them.
- High quality tracking and monitoring systems had been put in place since the last inspection, and these have the potential to improve consistency of practice.
- A number of children and young people experienced delays in moving to their 'forever families'. Tracking processes are now in place and at the next inspection we will review the impact of these on outcomes for children and young people.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	4 - Good
How good is our leadership?	4 - Good
How good is our staff team?	4 - Good
How well is our care and support planned?	4 - Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 4 - Good

We made an overall evaluation of good for this key question, as several important strengths, taken together, clearly outweighed areas of improvement. Whilst some improvements were needed, the strengths identified had a significant positive impact on children and young people's experiences.

Children enjoyed, warm, affectionate, and trusting relationships with their caregivers promoting a sense of belonging and security. We were confident that young people were experiencing love with their needs fully met by committed fostering families.

Caregivers we spoke to valued staff knowledge, skills, commitment, and responsiveness. We saw evidence of regular monthly visits taking place and carers confirmed they were getting high levels of support. Continuity of relationships had been impacted by high staff turnover, however, the service was now fully staffed and caregiver families reported positive relationships with staff which helped to support positive outcomes. Caregivers reported a weaker relationship with managers in the service.

Children and young people experienced individualised care, were achieving positive outcomes in education, and were involved in their communities. Caregiver families supported children to have fulfilling lives with high aspirations for success. This supportive and positive culture contributed to positive outcomes for children and young people.

Supervising social workers, and carer training supported caregivers to adopt informed approaches to caring for children and helping them to feel loved and valued. A training calendar was in place which outlined training opportunities throughout the year. Caregiver families also had access to support groups and family events. The service would benefit from strengthening relationships with existing caregivers and improving caregiver attendance at training, support groups and events.

Whilst we saw that there had been some positive efforts to support children and young people to maintain important relationships, we were of the view that further work is required to improve how the service supports the need for sibling relationships for children who do not live in the same fostering household to build meaningful relationships. We will therefore repeat the area for improvement made at the last inspection. See area for improvement 1.

Young people's safety and welfare was being protected due to the consistent completion of safe caring plans. We asked to service to ensure that these documents are reviewed in line with their policy. Unannounced visits are now taking place in line with policies and procedures.

Children and young people's needs in relation to their life story was well promoted by the service. Life story training has been provided to staff and caregivers and a new departmental life story policy is being developed which aims to ensure consistency in approach across children's social work and placement services.

When children and young people were moving to live with caregiver families, we saw improved approaches in identifying and matching their needs to carer skills. Whilst we saw positive improvements, the service would benefit from further strengthening matching processes to ensure that the needs of other children living in the household are considered and that any supports needed are clearly recorded. We have made this an area for improvement. (See area for improvement 2).

At the last inspection we found significant drift and delay in permanence planning and lack of service overview of this which negatively impacted on outcomes. Improved tracking arrangements are now in place across placement services, involving children's social work managers and independent reviewing officer. We need to see how these new tracking arrangements will impact on outcomes and continuing to improve permanence planning for children. This will form an area for improvement in this inspection. (See area for improvement 3).

Areas for improvement

1. To promote long term positive relationships between brothers and sisters, the provider should have a plan to facilitate family time between sibling groups who live in different fostering families. This should include but not be limited to a review of the needs for family time for sibling groups in different fostering families with a plan to facilitate appropriate ongoing relationships between brothers and sisters.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am supported to manage my relationships with my family, friends or partner in a way that suits my wellbeing.' (HSCS 2.18)

2. To improve outcomes for young people, the service should further strengthen their referral and matching processes to ensure that there is a clear identification of a fostering family's ability to meet the needs of a child before the child joins this family. This should ensure that the needs of existing children in the fostering family have been included.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My care and support meets my needs and is right for me.' (HSCS 1.19)

3. To support long term stability for children and young people the service should ensure tracking systems in place are used to robustly monitor and evidence improved outcomes.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'As a child or young person needing permanent alternative care, I experience this without unnecessary delay' (HSCS 1.16)

How good is our leadership? 4 - Good

We made an overall evaluation of good for this key question, as several important strengths, taken together, clearly outweighed areas of improvement. Whilst some improvements were needed, the strengths identified had a significant positive impact on children and young people's experiences.

We saw significant improvements in quality assurance systems had been made since the last inspection ensuring key elements of practice to safeguard welfare were undertaken. A new policy team with a role to review complaints and quality assurance has brought extra capacity to develop procedures and to embed a learning culture from all aspects of service delivery. The service manager has embedded a range of quality assurance processes to inform ongoing development which has created a foundation for continuous improvement.

We assess there was now a more consistent overview of key processes, such as carer checks, foster carer reviews, unannounced visits and safer caring plans. We discussed with the service that they should progress similar tracking of incidents, accidents, and allegations which we are confident will be progressed. These changes are at the early stage, however, we are confident that there is now an increased capacity for improvement and development.

Children's outcomes were being improved through the implementation of a new policy regarding unplanned endings which evidences there is an overview of unplanned endings which highlights learning and actions to be taken forward.

The Fostering and Adoption Panel and Agency Decision Maker provides scrutiny to carer reviews and applications for approval for fostering families and they were able to challenge assessments presented to them. We heard that here is a high level of communication between the independent chair, the Agency Decision Maker and panel co-ordinator. Panel members are well supported through regular supervision and appraisal and have access to a range of learning and development opportunities.

Staff in the fostering and adoption team have told us that they are experiencing delays in decision making and are feeling that the managers do not understand the service. They described a sense of detachment from senior managers and there were some negative comments in our survey relating to management culture. Staff in the team expressed that seniors in the service lack autonomy which can impact on outcomes. It is anticipated that having a team manager in post will improve the speed of decision making.

We were encouraged to see that a lot of attention and action has been taken to support the quality assurance improvements needed within the service. Whilst these are positive developments many are very recent and therefore, we are unable to confidently report that outcomes have improved as a result. The comments relating to the negative view of the management culture do give us cause for concern. We will review both of these at the next inspection.

How good is our staff team? 4 - Good

We have made an evaluation of good for this key question, as several important strengths, taken together, clearly outweigh areas for improvement. Whilst some improvements were needed, the strengths identified had a significant positive impact on children and young people's experiences.

Staff practice observed through tracked cases and individual discussions aligned to the values and principles of the Health and Social Care Standards. There has been a high staff turnover in the team since the last inspection which has impacted on consistency of relationships for many caregivers and children and young people. We received positive feedback from caregivers in relation to the knowledge and competence of workers within the team. We heard that staff had worked hard to build genuine and trusting relationships. Staff in the team were knowledgeable and displayed a passion for their area of practice.

We saw improved relationships with children's social work teams with this leading to improved support and positive outcomes for caregivers and children and young people.

Staff in the team had received consistent supervision and had access to annual appraisal which identified learning and development needs. Staff also had access to a range of learning and development opportunities, including external training offered by the Fostering Network. Newly qualified staff were supported by a buddy system and clear induction procedures were in place.

Morale in the team was high and staff felt supported by colleagues and their line manager. Staff told us they felt a disconnect with senior management in the service and this has been discussed in Key Question 2. At the time of inspection, the post of Team Manager was vacant which reduced management capacity and support to staff with senior managers providing cover alongside their existing workload.

Greater clarity in policies and procedures had supported the integration of new staff and had improved consistency of practice.

How well is our care and support planned? 4 - Good

We have made an evaluation of good for this key question, as several important strengths, taken together, clearly outweigh areas for improvement. Whilst some improvements were needed, the strengths identified had a significant positive impact on children and young people's experiences.

Young people's plans identified involvement and input from a range of professionals supporting the child and their caregiver family. We found that Looked After and Accommodated reviews were taking place regularly and in line with timescales. This contributed to comprehensive assessments which promote positive outcomes for children and young people.

The voice of young people was evidenced through their contributions to foster carer reviews and Looked After reviews with their voices being seen within assessments and minutes. Formal advocacy was used where required. The service has improved the range of methods used to ensure that children and young people are able to lead and direct their own care and we look forward to reviewing these continued efforts at the next inspection to ensure that views are sought in a meaningful way.

Young people and their caregiver's safety was protected. Family policies and risk assessments for individual children and young people were consistently completed and the majority of those we saw were up to date.

Risk assessments seen as part of our case tracking were completed to a reasonable standard and reflected risks in most cases. We saw that these reflected the dynamics within the household and improved the protection and safety of the children, young people and adults within the home, however, some would benefit from a more holistic approach and greater analysis.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 30 June 2022 the provider must ensure that clear systems are in place to monitor outcomes for children in need of permanent substitute care. To do this the provider must as a minimum:

a) ensure robust tracking arrangements are in place for children at all stages of their care journey and that drift and delay is addressed at each stage of the process.

b) ensure a robust approach is taken to family finding when children are identified as needing permanent care to ensure that their care needs can met by the right fostering family.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'As a child or young person needing permanent alternative care, I experience this without unnecessary delay' (HSCS 1.16)

This requirement was made on 18 March 2022.

Action taken on previous requirement

The service now has in place a permanence tracker. Whilst this is at the early stages of implementation, we were of the view that this will support the tracking of children at all stages of their journey and that drift and delay will be addressed at each stage of the process. We have made a formal area for improvement asking the service to monitor and evidence improved outcomes for the next inspection.

Met - within timescales

Requirement 2

By 30 June 2022 the provider must ensure that there is a clear identification of a fostering family's ability to meet the needs of a child before the child joins this family. To do this the provider must as a minimum:

a) have clear a clear referral process which outlines the needs of children needing alternative care from fostering families

b) identify carer strengths and vulnerabilities in relation to meeting the needs of a specific child and outlining any additional support required to ensure that children's needs are fully met

c) ensure planning meetings take place when children join fostering families to review children's needs

d) ensure panel members have full information for matching panels including minutes of linking meetings.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'My care and support meets my needs and is right for me.' (HSCS 1.19)

This requirement was made on 18 March 2022.

Action taken on previous requirement

The service has made progress in relation to this requirement, however, further action is needed to ensure that positive outcomes are supported by good matching processes. This will form a formal area for improvement from this inspection.

Not met

Requirement 3

By 30 June 2022 the provider must ensure that robust quality assurance processes are in place to monitor key areas of performance within fostering regulations with monitoring and review to identify areas of continuous improvement.

To do this, the provider must as a minimum ensure:

a) unannounced visits take place within required timescales

b) individual safer caring plans are reviewed regularly in response to changing need
c) full carer checks are monitored and kept up to date.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience high quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11)

This requirement was made on 18 March 2022.

Action taken on previous requirement

The service has made progress in relation to this requirement. There are now trackers in place which ensure that checks, unannounced visits and safer caring policies are recorded and monitored. Staff supervision records evidence that there is an additional layer of quality assurance through the recording and discussing of key areas of performance. Whilst these tracking and quality assurance systems are in their early stages, we were confident that they would support continued improvement.

Met - within timescales

Requirement 4

By 30 June 2022 the provider must ensure that all staff are fully trained and supported effectively to provide consistent support to fostering families. To do this the provider must as a minimum ensure:

a) there is a clear induction process for new staff joining the service
b) there is a clear training plan for all staff
c) all staff have regular access to annual appraisal
d) there is continuity of supervisory relationships for all staff
e) exit interviews are undertaken and information analysed to understand reasons for staff turnover so that this can be addressed.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the SSSC's Code of Practice for Employers of Social Service Workers, which state that the employer will: 'provide effective, regular supervision to social service workers to support them to develop and improve through reflective practice' (3.5).

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

This requirement was made on 18 March 2022.

Action taken on previous requirement

We saw that the service now had in place a range of training opportunities for staff. These evidenced a high level of training completed and available for the staff team. New staff had received a full induction and they reported feeling supported when joining the service. Regular supervision was in place with annual appraisal. This was ensuring consistent support to fostering families.

Met - within timescales

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To promote long term positive relationships between brothers and sisters, the provider should have a plan to facilitate family time between sibling groups who live in different fostering families. This should include but not be limited to a review of the needs for family time for sibling groups in different fostering families with a plan to facilitate appropriate ongoing relationships between brothers and sisters.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am supported to manage my relationships with my family, friends or partner in a way that suits my wellbeing.' (HSCS 2.18)

This area for improvement was made on 18 March 2022.

Action taken since then

We saw limited evidence of improvements in relation to this area for improvement. This area for improvement will be repeated.

Previous area for improvement 2

To ensure all children have a clear understanding of their past the provider should improve its approach to life story work. This should include but is not limited to, implementing a consistent approach to gathering and storing important life story information and providing specific training to staff and carers about how life story work should be approached.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am supported to be emotionally resilient, have a strong sense of my own identity and wellbeing, and address any experiences of trauma or neglect.' (HSCS, 1.29)

This area for improvement was made on 18 March 2022.

Action taken since then

We saw that the service had made improvements in their approach to life story work. Training had been provided to both staff and carers.

Previous area for improvement 3

To support fostering families to fully support children in their care, the provider should improve the support available to carers in particular in relation to managing challenging behaviour. This should include but is not limited to the creation of a clear programme of training to create a shared vision of the approach to care to ensure fostering families are fully supported to meet the needs of children.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience high quality care and support based on relevant evidence, guidance and best practice.' (HSCS 4.11)

This area for improvement was made on 18 March 2022.

Action taken since then

We saw that the service had a robust and varied training calendar available to their care giver families.

Previous area for improvement 4

To keep all children safe from harm, the provider should ensure that all foster carers are aware of their responsibilities in relation to child protection. This should include but is not limited to the provision of specific training in child protection for foster carers.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities.' (HSCS 3.20)

This area for improvement was made on 18 March 2022.

Action taken since then

We were confident that this area for improvement had been met as the service had in place regular Child Protection and safer caring training. In addition, we could see that in recent months the service had looked to improve their recording of safer caring and risk assessment documentation. This is at the early stages so will be reviewed fully at the next inspection.

Previous area for improvement 5

To promote positive outcomes, the provider should ensure that all staff understand their roles and responsibilities in relation to quality assurance. This should include but is not limited to improving internal quality assurance processes and ensuring staff are sufficiently supported to practice effectively.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes.' (HSCS 4.19)

This area for improvement was made on 18 March 2022.

Action taken since then

Quality assurance frameworks for the service have been developed. Whilst we felt that this area for improvement has been met, we are of the view that this is at the early stages therefore the impact of this will be reviewed at the next inspection.

Previous area for improvement 6

To promote positive outcomes for all children, the provider should develop a reflective learning culture when unplanned endings have occurred. This should include but is not limited to a clear procedure for how unplanned endings will be reviewed with meetings that identify clear learning and action points for service improvement.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I receive an apology if things go wrong with my care and support or my human rights are not respected, and the organisation takes responsibility for its actions.' (HSCS 4.4

This area for improvement was made on 18 March 2022.

Action taken since then

The service has put in place an unplanned endings tracker which pulls together learning points and actions required. The quality assurance team has oversight of this tracker and is progressing any learning and actions as required. This is a new process which will be reviewed at the next inspection.

Previous area for improvement 7

To promote children's welfare, the provider should ensure that children's reviews reflect the views of the young person and their fostering family. This should include but is not limited to, children, fostering families and fostering team staff providing written updates for children's reviews and improving how it gathers these views prior to meetings taking place.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I experience high quality care and support because people have the necessary information and resources.' (HSCS 4.27)

This area for improvement was made on 18 March 2022.

Action taken since then

We saw good evidence that young people's views were captured in review paperwork and that the use of Who Cares and advocacy workers had supported these views to be sought and shared.

Previous area for improvement 8

To ensure children and fostering families are included in discussions related to safer caring, the service should review its implementation of safer caring plans. This should include but not be limited to, reviewing formats of documentation and improving guidance to staff on how to engage children and fostering families in safer caring plans.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am as involved as I can be in agreeing and reviewing any restrictions to my independence, control and choice.' (HSCS 2.6)

This area for improvement was made on 18 March 2022.

Action taken since then

The service has introduced new safer caring documentation and processes. We were confident that the vast majority of families and young people now have updated safer caring reports which supports improved

outcomes for children and young people. Given that these developments are fairly recent, we will review this again at the next inspection.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	4 - Good
1.1 Children, young people. adults and their caregiver families experience compassion, dignity and respect	4 - Good
1.2 Children, young people and adults get the most out of life	4 - Good
1.3 Children, young people and adults' health and wellbeing benefits from the care and support they experience	4 - Good
1.4 Children, young people, adults and their caregiver families get the service that is right for them	4 - Good

How good is our leadership?	4 - Good
2.2 Quality assurance and improvement are led well	4 - Good

How good is our staff team?	4 - Good
3.2 Staff have the right knowledge, competence and development to support children, young people, adults and their caregiver families	4 - Good

How well is our care and support planned?	4 - Good
5.1 Assessment and care planning reflects the outcomes and wishes of children, young people and adults	4 - Good

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Moray Adoption Service
Adoption Service

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Telephone: 01343 563 568

Type of inspection:
Announced (short notice)

Completed on:
6 July 2023

Service provided by:
The Moray Council

Service provider number:
SP2003001892

Service no:
CS2004082047

About the service

Moray Adoption Service is a local authority adoption agency which recruits and supports adoptive families for children in need of permanent substitute care. The service is provided by a dedicated team of social workers.

About the inspection

This was a short notice inspection which took place between 19 June and 6 July. The inspection was carried out by two inspectors from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we spoke with one person using the service and spoke with three staff and management, observed practice and daily life, reviewed documents spoke with visiting professionals. We also received five responses to a survey sent to adopters in advance of the inspection.

Key messages

- Children were supported to maintain meaningful relationships with extended family members and were involved in the wider community.
- Young people required further support to maintain meaningful contact with siblings.
- Caregivers valued relationships with their social workers and we assessed that staff were skilled at supporting them.
- High quality tracking and monitoring systems had been out in place since the last inspection, and these have the potential to improve consistency of practice.
- A number of children and young people experienced delays in moving to their 'forever families'. Tracking processes are now in place and at the next inspection we will review the impact of these on outcomes for children and young people.
- Improvements in post adoption support had been made since the last inspection.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	4 - Good
How good is our leadership?	4 - Good
How good is our staff team?	4 - Good
How well is our care and support planned?	4 - Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 4 - Good

We have graded this key question as good, where there are a number of which taken together outweigh areas for improvement.

Adoptive families reported positive relationships with staff in the service which helped to support positive outcomes. One adopter told us "my social worker is very responsive and knowledgeable". Adopters felt comfortable during the assessment process to be open and honest, we saw examples of post adoption support delivered sensitively, supporting a child at their pace to understand their life story. Flexibility and choice for adoptive families had been promoted by the pilot of self directed support but this is still in its early stages and has not been widely used in the service.

Children and young people living in adoptive families were supported to maintain important relationships including siblings and previous carers. We saw examples of letter exchange with family being managed well and how, through life story work, connections with family were safely promoted by the service.

Children and young people living in adoptive families experienced individualised care, were achieving in education and had opportunities to lead fulfilling lives. Adoptive families were aware of their responsibilities as dual approved foster carers and the service had a robust approach to safeguarding. Adoptive families had access to training to help them to keep children safe, including online safety.

Children and young people's needs in relation to life story was well promoted by the service. The adoption team have led on life story training for carers and staff across the service, to support a new departmental life story policy which aims to ensure consistency in approach across children's social and placement services. This work is in its early stages and we look forward to seeing the impact at future inspections.

Adoptive families benefitted from access to a wide range of training and learning opportunities provided through the service including online training and courses provided by external providers. This included training in relation to Dyadic Developmental Practice, a trauma informed model of practice to support children to develop positive attachments. A training calendar was in place that outlined learning opportunities throughout the year. Adoptive families also had access to drop in sessions and family events were arranged to promote engagement with the service and build relationships.

Adoptive families were robustly assessed and there were clear processed for identifying appropriate matches. Staff in the adoption team had a role in family finding for children identified as in need of adoption, with referrals made at an early point to reduce drift and delay. Transitions for children moving to adoptive families were well planned based on individual need, with staff having a strong understanding of the theory base informing practice.

At the last inspection we found significant drift and delay in permanence planning and lack of service overview of this which negatively impacted on outcomes. Improved tracking arrangements are now in place across placement services, involving children's social work managers and independent reviewing officers. We need to see how these new tracking arrangements will impact on outcomes and continue to improve permanence planning for children and young people. This will form an area for improvement in this inspection (see area for improvement 1).

Areas for improvement

1. To support long term stability for children and young people, the service should ensure tracking systems in place are used to robustly monitor and evidence improved outcomes.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'As a child or young person needing permanent alternative care, I experience this without unnecessary delay' (HSCS 1.16).

How good is our leadership? 4 - Good

We have graded this key question as good, where there are a number of strengths which taken together outweigh areas for improvement.

We saw significant improvements in quality assurance systems had been made since the last inspection, ensuring key elements of practice to safeguard welfare were undertaken. A new policy team with a role to review complaints has brought extra capacity to develop procedures and to embed a learning culture from

all aspects of service delivery. The service manager has embedded a range of quality assurance processes to inform ongoing development which has created a foundation for continuous improvement.

We assess there was now a more consistent overview of key processes, such as carer checks, foster carer reviews, unannounced visit and safer caring plans. We discussed with the service that they should progress similar tracking of incidents, accidents and allegations which we are confident will be progressed. These changes are at the early stage, however, we are confident that there is now an increased capacity for improvement and development.

Children's outcomes were being improved through the implementation of a new policy regarding unplanned endings, which evidences there is an overview of unplanned endings which highlights learning and actions to be taken forward.

The Fostering and Adoption Panel and Agency Decision Maker provides scrutiny to carer review and applications for approval for adoptive families and were able to challenge assessments presented to them. We heard that here is a high level of communication between the independent chair, the Agency Decision Maker and panel co-ordinator. Panel members are well supported through regular supervision and appraisal and have access to a range of learning and development opportunities.

Staff in the fostering and adoption team have told us that they are experiencing delays in decision making and are feeling that the managers do not understand the service. They described a sense of detachment from senior managers and there were some negative comments in our survey relating to management culture. Staff in the team expressed that seniors in the service lack autonomy which can impact on outcomes. It is anticipated that having a team manager in post will improve the speed of decision making.

We were encouraged to see that a lot of attention and action has been taken to support the quality assurance improvements needed within the service. Whilst these are positive developments, many are very recent and, therefore, we are unable to confidently report that outcomes have improved as a result. The concerns expressed by staff relating to a negative view of the management culture do give us cause for concern. We will review both of these at the next inspection.

How good is our staff team? 4 - Good

We have graded this key question as good, where there are a number of strengths which taken together outweigh areas for improvement.

We received positive feedback from adopters in relation to the knowledge and competence of workers within the team. Staffing had been stable since the last inspection, which provided consistency of support to caregiver families. Staff in the team were experienced and knowledgeable with a passion for their area of practice. Staff were able to use their knowledge to promote development across the local authority, through leading on training for life story work across the local authority to improve how children and young people are supported to understand their life story.

Staff in the team had received consistent supervision, but there had been gaps in support in the past year where supervision had not taken place regularly. Staff also had access to an annual appraisal which identified learning and development needs. Staff had access to range of training, including external training offered by the fostering network.

Morale in the team was high and staff felt supported by colleagues and their line manager. Staff had felt a

disconnect with senior management in the service and this has been discussed in key question 2.2. At the time of the inspection the post of team manager was vacant, which reduced management capacity and support to staff with senior managers providing cover alongside their existing workload.

A buddy system was in place for new staff joining the service with clear induction procedures. Greater clarity in policies and procedures had supported the integration of new staff and had improved consistency of practice.

How well is our care and support planned? 4 - Good

We have graded this key question as good, where there are a number of strengths which taken together outweigh areas for improvement.

Adoptive families had access to responsive post adoption support. Since the last inspection, all adoptive families had been contacted to explain their rights to post adoption support. The service also held information sessions and were running regular drop ins and social events for adoptive families. The service had developed a new template for post adoption support and adoptive families had access to a range of training opportunities post approval to support them in their parenting role. We saw evidence of improved engagement with adoptive families, one adopter told us "After we adopted out child, we felt quite isolated, this seems to have changed in recent years, and I find lots of communication coming out from the team inviting us to meet ups and training".

Staff were skilled in delivering post adoption support and we saw examples of children benefitting from creative bespoke packages of support. The service is reflecting on how Self Directed Support can be used to promote positive outcomes for adoptive families. We did receive some feedback from adopters who were not aware of post adoption support plans and the service should continue to engage with families to ensure that all adoptive families know how to access support.

Individualised safer caring plans were in place for children living with adopters who were dual approved as foster carers and these were regularly reviewed. Staff from the adoption team contributed to planning for children through participation in statutory review meetings.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 30 June 2022, the provider must ensure that clear systems are in place to monitor outcomes for children in need of permanent substitute care.

To do this the provider must as a minimum:
a) ensure robust tracking arrangements are in place for children at all stages of their care journey and that drift and delay is addressed at each stage of the process

b) ensure a robust approach is taken to family finding when children are identified as needing permanent care to ensure that their care needs can be best met.

This is to comply with Regulation 4(1)(a) of the The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'As a child or young person needing permanent alternative care, I experience this without unnecessary delay' (HSCS 1.16).

This requirement was made on 18 March 2022.

Action taken on previous requirement

The service now has in place a Permanence tracker. Whilst this is at the early stages of implementation, we were of the view that this will support the tracking of children at all stages of their journey and that drift and delay will be addressed at each stage of the process. We have made a formal area for improvement asking the service to monitor and evidence improved outcomes for the next inspection.

Met - within timescales

Requirement 2

By 30 June 2022, the provider must ensure that there is a clear identification of a caregiver family's ability to meet the needs of a child before the child joins this family.

To do this the provider must as a minimum:
a) have clear a clear referral process which outlines the needs of children needing alternative care from caregiver families
b) identify carer strengths and vulnerabilities in relation to meeting the needs of a specific child and outlining any additional support required to ensure that children's needs are fully met
c) ensure planning meetings take place when children join caregiver families to review children's needs
d) ensure panel members have full information for matching panels including minutes of linking meetings.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'My care and support meets my needs and is right for me' (HSCS 1.19).

This requirement was made on 18 March 2022.

Action taken on previous requirement

The service has made progress in relation to this requirement, however, further action is needed to ensure that positive outcomes are supported by good matching processes. This will form a formal area for improvement for the Moray Fostering Service which has been inspected alongside this service.

Met - within timescales

Requirement 3

By 30 June 2022, the provider must ensure that all dual registered foster carer/adopters are supported in line with fostering legislation and best practice.

To do this the provider must as a minimum:
a) undertake foster care agreements in line with best practice guidance and statutory requirements
b) ensure systems are in place for identification and panel review of dual registered prospective adopters
c) ensure that all carers are supported through regular supervision and have access to relevant training
d) ensure that the safety of children and young people is improved through unannounced visits
e) Individual safer caring plans are developed and reviewed regularly in response to changing need
f) full carers checks are monitored and kept up to date.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I receive high quality care and support based on relevant evidence, guidance and best practice' (HSCS 4.11).

This requirement was made on 18 March 2022.

Action taken on previous requirement
Improved procedures for supporting adoptive families dual approved as foster carers in place.

Met - within timescales

Requirement 4

By 30 June 2022, the provider must ensure that all children and young people are cared for in safe and well-matched adoptive families. To do this, the provider must as a minimum:

a) ensure that Panel members are all provided with relevant documentation to inform the matching of young people with their adoptive families.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'My care and support meets my needs and is right for me' (HSCS 1.19).

This requirement was made on 18 March 2022.

Action taken on previous requirement
Change in business process, panel members now in receipt of full paperwork for panels.

Met - within timescales

Requirement 5

By 30 June 2022, the provider must ensure that all staff are fully trained and supported effectively to provide consistent support to caregiver families.

To do this the provider must as a minimum ensure:
a) there is a clear induction process for new staff joining the service
b) there is a clear training plan for all staff
c) all staff have regular access to annual appraisal
d) there is continuity of supervisory relationships for all staff
e) exit interviews are undertaken and information analysed to understand reasons for staff turnover so that this can be addressed.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

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

This requirement was made on 18 March 2022.

Action taken on previous requirement

We saw that the service now had in place a range of training opportunities for staff. These evidenced a high level of training completed and available for the staff team. New staff had received a full induction and they reported feeling supported when joining the service. Regular supervision was in place with annual appraisal. This was ensuring consistent support to fostering families.

Met - within timescales

Requirement 6

By 30 June 2022, the provider must adopt a strategic approach to providing post adoption support services.

To do this, the provider must as a minimum ensure:
a) all adoptive families have an adoption support plan in place and that this is reviewed in line with legislation and good practice guidance
b) ensure that staff are fully aware of their roles and adopters are aware of their rights in relation to the development of adoption support plans.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that the quality of care and support is consistent with the Health and Social Care Standards (HSCS) which state:
'I am supported and cared for sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty' (HSCS 3.18).

This requirement was made on 18 March 2022.

Action taken on previous requirement
Improved approve to post adoption support evidenced during inspection.

Met - within timescales

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To promote long term positive relationships between brothers and sisters, the provider should have a plan to facilitate family time between sibling groups who live in different fostering families. This should include but not be limited to a review of the needs for family time for sibling groups in different fostering families, with a plan to facilitate appropriate ongoing relationships between brothers and sisters.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:
'I am supported to manage my relationships with my family, friends or partner in a way that suits my wellbeing' (HSCS 2.18).

This area for improvement was made on 18 March 2022.

Action taken since then
We saw limited evidence of improvements in relation to this area for improvement. This area for improvement will be repeated for the fostering service that was inspected alongside the adoption service.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	4 - Good
1.1 Children, young people. adults and their caregiver families experience compassion, dignity and respect	5 - Very Good
1.2 Children, young people and adults get the most out of life	5 - Very Good
1.3 Children, young people and adults' health and wellbeing benefits from the care and support they experience	4 - Good
1.4 Children, young people, adults and their caregiver families get the service that is right for them	4 - Good

How good is our leadership?	4 - Good
2.2 Quality assurance and improvement are led well	4 - Good

How good is our staff team?	4 - Good
3.2 Staff have the right knowledge, competence and development to support children, young people, adults and their caregiver families	4 - Good

How well is our care and support planned?	4 - Good
5.1 Assessment and care planning reflects the outcomes and wishes of children, young people and adults	4 - Good

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Moray Continuing Care Services
Adult Placement Service

Rose Cottage
PO Box 67
Elgin
IV30 9BX

Telephone: 01343 563 579

Type of inspection:
Announced (short notice)

Completed on:
6 July 2023

Service provided by:
The Moray Council

Service provider number:
SP2003001892

Service no:
CS2020379353

About the service

Moray Continuing Care is an adult placement service linked to the Moray Fostering Service. The service supports young people to remain living with their carers beyond the age of 18.

Inspections of the fostering and adoption services have been undertaken and separate reports have been completed.

About the inspection

This was a short notice inspection which took place between 19 June 2023 and 6 July 2023. The inspection was carried out by two inspectors from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with one young person using the service and their caregiver
- spoke with ten staff and management
- observed practice and daily life
- reviewed documents
- spoke with visiting professionals.

Key messages

- Young people experienced supportive, enduring relationships with fostering families beyond the age of 18 that provided them with a sense of belonging.
- Young people were supported to maintain meaningful relationships with extended family members and were involved in the wider community.
- Caregivers valued relationships with their social workers, and we assessed that staff were skilled at supporting them.
- High quality tracking and monitoring systems had been put in place since the last inspection, and these have the potential to improve consistency of practice.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	4 - Good
How good is our leadership?	4 - Good
How good is our staff team?	4 - Good
How well is our care and support planned?	4 - Good

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 4 - Good

We made an overall evaluation of good for this key question, as several important strengths, taken together, clearly outweighed areas of improvement. Whilst some improvements were needed, the strengths identified had a significant positive impact on young people's experiences.

We saw that a number of young people were supported to remain within their caregiver families past the age of 18. Young people enjoyed, warm, affectionate, and trusting relationships with their caregivers promoting a sense of belonging and security. We were confident that young people were experiencing love with their needs fully met by committed fostering families.

Caregivers we spoke to valued staff knowledge, skills, commitment, and responsiveness. We saw evidence of regular monthly visits taking place and carers confirmed they were getting high levels of support. Continuity of relationships had been impacted by high staff turnover, however, the service was now fully staffed and caregiver families reported positive relationships with staff which helped to support positive outcomes.

Caregivers reported a weaker relationship with managers in the service.

Young people experienced individualised care, were achieving positive outcomes in education and employment, and were involved in their communities. Caregiver families supported young people to have fulfilling lives with high aspirations for success. This supportive and positive culture contributed to positive outcomes for young people.

Supervising social workers and carer training supported caregivers to adopt informed approaches to caring for young people and helped them to feel loved and valued. A training calendar was in place which outlined training opportunities throughout the year. Caregiver families also had access to support groups and family events. The service would benefit from strengthening relationships with existing caregivers and improving caregiver attendance at training, support groups and events.

Young people were supported to maintain important relationships including siblings and previous carers. We saw good practice around how young people are supported to have time with birth families.

Young people's safety and welfare was being protected due to the consistent completion of safe caring plans. We asked to service to ensure that these documents are reviewed in line with their policy, as from our case tracking, we found that some of these had not been reviewed. Unannounced visits are now taking place in line with policies and procedures.

Young people's needs in relation to life story work was well promoted by the service. Life story training has been provided to staff and caregivers and a new departmental life story policy is being developed which aims to ensure consistency in approach across children's social work and placement services. During this inspection we discussed the need for life story work to remain an important feature of the lives of those young people living in continuing care.

How good is our leadership? 4 - Good

We made an overall evaluation of good for this key question, as several important strengths, taken together, clearly outweighed areas of improvement. Whilst some improvements were needed, the strengths identified had a significant positive impact on young people's experiences.

We saw significant improvements in quality assurance systems had been made since the last inspection ensuring key elements of practice to safeguard welfare were undertaken. A new policy team with a role to review complaints has brought extra capacity to develop procedures and to embed a learning culture from all aspects of service delivery. The service manager has embedded a range of quality assurance processes to inform ongoing development which has created a foundation for continuous improvement.

We assess there was now a more consistent overview of key processes, such as carer checks, foster carer reviews, unannounced visit and safer caring plans. We discussed with the service that they should progress similar tracking of incidents, accidents and allegations which we are confident will be progressed. These changes are at the early stage, however, we are confident that there is now an increased capacity for improvement and development.

Children's outcomes were being improved through the implementation of a new policy regarding unplanned endings which evidences there is an overview of unplanned endings which highlights learning and actions to be taken forward.

The Fostering and Adoption Panel and Agency Decision Maker provides scrutiny to carer review and applications for approval for fostering families and they were able to challenge assessments presented to them. We heard that here is a high level of communication between the independent chair, the Agency Decision Maker and panel co-ordinator. Panel members are well supported through regular supervision and appraisal and have access to a range of learning and development opportunities.

Staff in the fostering and adoption team have told us that they are experiencing delays in decision making and are feeling that the managers do not understand the service. They described a sense of detachment from senior managers and there were some negative comments in our survey relating to management culture. Staff in the team expressed that seniors in the service lack autonomy which can impact on outcomes. It is anticipated that having a team manager in post will improve the speed of decision making.

We were encouraged to see that a lot of attention and action has been taken to support the quality assurance improvements needed within the service. Whilst these are positive developments many are very recent and therefore, we are unable to confidently report that outcomes have improved as a result. The comments relating to the negative view of the management culture do give us cause for concern. We will review both of these at the next inspection.

How good is our staff team? 4 - Good

We have made an evaluation of good for this key question, as several important strengths, taken together, clearly outweigh areas for improvement. Whilst some improvements were needed, the strengths identified had a significant positive impact on children and young people's experiences.

Staff practice observed through tracked cases and individual discussions aligned to the values and principles of the Health and Social Care Standards. There has been a high staff turnover in the team since the last inspection which has impacted on consistency of relationships for many caregivers and children and young people. We received positive feedback from caregivers in relation to the knowledge and competence of workers within the team. We heard that staff had worked hard to build genuine and trusting relationships. Staff in the team were knowledgeable and displayed a passion for their area of practice.

We saw improved relationships with children's social work teams with this leading to improved support and positive outcomes for caregivers and children and young people.

Staff in the team had received consistent supervision and had access to annual appraisal which identified learning and development needs. Staff also had access to a range of learning and development opportunities, including external training offered by the Fostering Network. Newly qualified staff were supported by a buddy system and clear induction procedures were in place.

Morale in the team was high and staff felt supported by colleagues and their line manager. Staff told us they felt a disconnect with senior management in the service and this has been discussed in Key Question 2. At the time of inspection, the post of Team Manager was vacant which reduced management capacity and support to staff with senior managers providing cover alongside their existing workload.

Greater clarity in policies and procedures had supported the integration of new staff and had improved consistency of practice.

How well is our care and support planned? 4 - Good

We have made an evaluation of good for this key question, as several important strengths, taken together, clearly outweigh areas for improvement. Whilst some improvements were needed, the strengths identified had a significant positive impact on children and young people's experiences.

Young people's plans identified involvement and input from a range of professionals supporting the child and their caregiver family. We found that Looked After and Accommodated reviews were taking place regularly and in line with timescales. This contributed to comprehensive assessments which promote positive outcomes for young people.

There was a clear assessment and review process in place for all young people within continuing care and for their caregivers. Welfare assessments and Pathways plans were detailed reports which clearly outlined the needs and wishes of young people. We saw evidence of regular review of these.

We saw positive outcomes for young people due to the multi-agency working from a range of parties.

The voice of young people was evidenced through their contributions to foster carer reviews and Looked After reviews with their voices being seen within assessments and minutes. Formal advocacy was used where required. The service has improved the range of methods used to ensure that young people are able to lead and direct their own care and we look forward to reviewing these continued efforts at the next inspection to ensure that views are sought in a meaningful way.

Young people and their caregiver's safety was protected. Family polices and risk assessments for individual young people were consistently completed and the majority of those we saw were up to date.

Risk assessments seen as part of our case tracking were completed to a reasonable standard and reflected risks in most cases. We saw that these reflected the dynamics within the household and improved the protection and safety of the children, young people and adults within the home, however, some would benefit from a more holistic approach and greater analysis.

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 30 June 2022 the provider must ensure that all staff are fully trained and supported effectively to provide consistent support to fostering families. To do this the provider must as a minimum ensure:

a) there is a clear induction process for new staff joining the service
b) there is a clear training plan for all staff
c) all staff have regular access to annual appraisal
d) there is continuity of supervisory relationships for all staff
e) exit interviews are undertaken and information analysed to understand reasons for staff turnover so that

this can be addressed.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011(SSI 2011/210).

This is to ensure that care and support is consistent with the SSSC's Code of Practice for Employers of Social Service Workers, which state that the employer will: 'provide effective, regular supervision to social service workers to support them to develop and improve through reflective practice' (3.5).

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

This requirement was made on 18 March 2022.

Action taken on previous requirement

We saw that the service now had in place a range of training opportunities for staff. These evidenced a high level of training completed and available for the staff team. New staff had received a full induction and they reported feeling supported when joining the service. Regular supervision was in place with annual appraisal. This was ensuring consistent support to fostering families.

Met - within timescales

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

To keep all young people safe from harm, the provider should ensure that all continuing care carers are aware of their responsibilities in relation to adult protection. This should include but is not limited to the provision of specific training in adult protection for adult carers.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that: 'I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities.' (HSCS 3.20).

This area for improvement was made on 18 March 2022.

Action taken since then

The service has provided adult protection and safer caring training to carers. There is a training calendar in place with a range of learning and development opportunities.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	4 - Good
1.1 Children, young people. adults and their caregiver families experience compassion, dignity and respect	5 - Very Good
1.2 Children, young people and adults get the most out of life	4 - Good
1.3 Children, young people and adults' health and wellbeing benefits from the care and support they experience	5 - Very Good
1.4 Children, young people, adults and their caregiver families get the service that is right for them	4 - Good

How good is our leadership?	4 - Good
2.2 Quality assurance and improvement are led well	4 - Good

How good is our staff team?	4 - Good
3.2 Staff have the right knowledge, competence and development to support children, young people, adults and their caregiver families	4 - Good

How well is our care and support planned?	4 - Good
5.1 Assessment and care planning reflects the outcomes and wishes of children, young people and adults	4 - Good

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REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 30 NOVEMBER 2023**

SUBJECT: **DRUG RELATED DEATHS IN MORAY**

BY: **INTERIM INTEGRATED SERVICE MANAGER**

1. REASON FOR REPORT

1.1 To update the Committee about drug-related deaths in Moray.

2. RECOMMENDATION

2.1 It is recommended that the Committee consider and note:

i) the drug related death figures for Moray;

ii) the National Records of Scotland Publication into drug-related deaths across Scotland in 2022;

iii) ongoing work of the service in relation to the Multi Agency Risk System (MARS) process; and

iv) progress on the delivery of the Medication Assisted Treatment (MAT) Standards implemented by the Scottish Government in May 2021.

3. BACKGROUND

3.1 The National Records of Scotland (NRS) publish, annually, the Drug-related Deaths in Scotland figures. The Statistics of drug-related deaths in 2022 and earlier years, broken down by age, sex, substances implicated in the death, underlying cause of death, and NHS Board and Council areas, are available online: Drug related deaths decrease | National Records of Scotland (nrscotland.gov.uk)];

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 NRS confirmed that Moray had 9 confirmed drug related deaths in 2022, reduced from 15 in 2021.

4.2 This is in line with the confirmed decrease across Scotland in 2022 compared to 2021.

4.3 The MARS meetings continue to take place on a regular basis for people known to be high-risk, currently there are 16 people in the process.

4.4 Good progress is continuing towards achieving the MAT standards. The arrival of updated guidance is expected, with regards to standards 1 – 5 and formal guidance for standards 6 – 10. There will be changes to how experiential data is gathered and scored and receipt of updated guidance is awaited in relation to this, expected to be end of October 2023.

4.5 Drug Related Death Meetings are chaired and meeting notes held confidentially. The frequency of meetings are demand led, there have been less of these recently as the number of drug related deaths reduce.

4.6 Moray Integrated Drug and Alcohol Service follow a review process of all the cases open in service for shared learning and debrief.

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

4.8 A local implementation group continues to meet fortnightly to support delivery of MAT standards in Moray. In addition, a working group meets weekly to create and review documentation to support MAT delivery.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"
Moray Drug and Alcohol Partnership Delivery Plan 2021 - 2024 (reviewed and revised November 2021)

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

Delivery in line with Rights, Respect and Recovery 2018 – Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths and the aim of the National Mission on Drug Deaths Plan 2022-2026 to reduce drug deaths and improve lives.

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

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

(e) Staffing Implications

Additional staff have already been appointed to support delivery of MAT standards, as well as meet increased demand on services. However, there is a potential for there to be further staffing implications as demand on services increases. For example, as the number of people seeking to access support for their addictions increases the service may need to recruit further staff to meet this demand.

(f) Property

Current accommodation is not fit for purpose, and does not allow service to comply with MAT standards. In addition, colocation with the Justice Service can be seen as a barrier to people accessing treatment. Work is ongoing to secure alternative premises for the service.

(g) Equalities/Socio Economic Impact

None arising directly from this report as there is no change to policy.

(h) Climate Change and Biodiversity Impacts

None arising directly from this report.

(i) Consultations

Public Protection Lead, Moray Alcohol and Drug Partnership Manager, Clinical Team Lead, Moray Integrated Drug and Alcohol Service and Caroline O'Connor, Committee Services Officer, Moray Council. Comments have been incorporated in this report.

6. CONCLUSION

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

Author of Report: Kathryn Kinnear, Interim Integrated Service Manager, Mental Health and Substance Misuse Service

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 30 NOVEMBER 2023**

SUBJECT: **HEALTH AND SOCIAL CARE MORAY (HSCM) CLINICAL AND CARE GOVERNANCE GROUP ESCALATION REPORT**

BY: **CHIEF NURSE, MORAY**

1. REASON FOR REPORT

1.1 To inform the Committee of progress and exceptions reported to the Clinical and Care Governance Group since the last report to Committee in August 2023.

2. RECOMMENDATION

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

3. BACKGROUND

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

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

3.3 As reported to this Committee on 29 October 2020 (para 5 of the minute refers) Social Care representatives attend the Clinical Governance Group so the group was renamed HSCM Clinical and Care Governance Group (CCGG).

3.4 A refresh of the Terms of Reference for the HSCM CCGG has taken place and there is a separate report on today's agenda which sets out refreshed framework across the Moray Portfolio and also those alignments that are required with NHS Grampian and Moray Council.

3.5 This report contains information from 3 minute briefs presented to HSCM CCGG from Clinical Service Groups / departments. This report also contains further information relating to feedback and incidents / adverse events reported via Datix and areas of concern / risk and good practice shared during the reporting period.

3.6 The reporting schedule of the CCGG does not always align to quarterly reporting to the committee. It has been agreed that the Escalation Report should include the CCGG meetings between committee scheduling; this may not always be quarterly.

3.7 The CCGG met three 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 processes in place to meet / mitigate the report recommendations. Overview of items discussed during this reporting period are listed below:

- CRM Minutes
- External Reports
- Service Updates
- Adverse Events and Duty of Candour
- HSCM Risk Register
- Complaints / Feedback
- Update from Practice Governance Group

Areas of achievement / Good Practice

Out of Hours Community Nursing (covering Aberdeenshire and Moray)

4.2 As a result of the notice period served by Marie Curie detailing their inability to continue to deliver the current Rapid Response Out Of Hours Community Nursing contract as of 30 September 2023, NHS Grampian have taken this service over as of 1 October 2023.

4.3 The revised service to date is working well with positive feedback regarding the induction, support and leadership that has been provided to the staff who have been Tupe'd over to NHS Grampian. The recruitment of new staff for this service has also been positive for both Health Care Support Worker posts as well as Registered Nurses. This positive outcome has also improved delivery of care out of hours with an increase in workforce and shifts covered to support patients across both Moray and Aberdeenshire.

Day of Care Audit

4.4 As previously reported, a senior team of auditors spent two days carrying out the Day of Care Survey and Qualitative Interviewing in both Moray Community Hospitals and Dr Gray's Hospital at the beginning of this year. The Day of Care Survey is a National Tool and the team plan to repeat it next year. Knowing the patient profile allows a greater understanding of issues preventing discharge and provides data to support change.

Moray Public Dental Service (PDS)

4.5 There remains a chronic NHS dental access problem in Moray. Urgent dental care provision in Moray remains comprehensive.

4.6 NHS dental reform has been introduced by the Scottish Government in an effort to support the oral health needs of every patient in Scotland, from 1 November 2023. The move will impact on the attractiveness of NHS provision for General Dental Practitioners and subsequently aims to improve NHS dental access. NHS dental fees for non-exempt patients are due to rise under this Reform.

4.7 PDS Clinical Lead has met with both Moray GP Leads and a new pathway is being developed to facilitate referrals of vulnerable Priority Group dental patients from GPs to Moray PDS. HSCM's Communication and Engagement Officer has issued a media release promoting the Dental Information and Advise Line (DIAL) service, this also went out on social media platforms and website highlighting the service.

Nursing Update

4.8 Nursing workforce continues to be challenged across many services due to both recruitment and retention issues. A number of new Graduate Nurses across Dr Gray's Hospital and HSCM have been recruited and ongoing support is in place for these new colleagues as they are inducted into their new roles. Nursing teams continue to review their workforce requirements in line with clinical activity and patient acuity, as well as changes in service developments.

Community Learning Disability Team

4.9 As reported in August, a short life working group was commissioned by the Grampian Public Protection Committee, chaired by Kenny O'Brien, Public Protection lead for NHS Grampian. This group also includes Adult Support and Protection (ASP) leads across Moray, Aberdeenshire and City, Moray Adult with Incapacity (AWI) Consultant Practitioner: Bridget Stone, Psychology lead: Judith Wishart, Psychiatry lead: Matt Collyer and others from across Grampian representing Health and Social Work.

4.10 The group are developing a pathway for those adults deemed to be at risk, or meeting the criteria for ASP. The group anticipate completion of the pathway by March 2024. The pathway as it is currently proposed will not take account of all adults requiring a capacity assessment or medical report for a guardianship application. This may still lead to people not able to benefit from the necessary support identified in their care plan or may delay a move to new accommodation. A period of consultation will take place before the final pathway is launched.

4.11 The service is still reliant on one Psychiatrist based in Aberdeen who is willing to undertake assessments reporting for the purpose of guardianship applications. This is at an average cost of £550 each, taking into account travel expenses.

4.12 With regard to the risk to the Learning Disability Team specifically, there is currently no one waiting for a capacity assessment or guardianship report which is an improvement from when this issue was initially escalated last year. However, the service is still without a Team Psychiatrist.

Clinical Risk Management (CRM)

4.13 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.

4.14 The group is attended by members of the Senior Management Team (SMT), Clinical Leads, Chief Nurse and relevant Service Managers. The purpose is to ensure that senior managers are assured of the standards of services and that where necessary investigations are carried out appropriately and learning opportunities identified and shared following adverse events and complaints.

4.15 It has been agreed that any learning identified will be presented and discussed at HSCM CCGG and HSCM Operational Management Team meeting (OMT) on a monthly basis.

Complaints and Feedback

4.16 HSCM complaints information for Quarter 2, 2023/24 is included in a separate report on today's agenda.

Adverse Events (AE)

4.17 Information about AE reported on Datix during Quarter 2, 2023/24 is available at **Appendix 1.**

Findings and Lessons Learned from incidents 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 are currently 2 Level 1 reviews in progress (at the time of reporting).

4.20 Key learnings during this reporting period, have been discussed at the CRM, and escalated to the NHS Grampian Cross System and Quality Safety Group to ensure actions are taken forward on a Grampian wide basis. It should also be noted that any pharmacy related adverse events are discussed on a Grampian wide basis at the Pharmacy Performance and Governance Group meetings as required and key updates disseminated to all staff in both the weekly community pharmacy updates and medication safety briefs which are issued monthly

HSCM Risk Register

4.21 Each Clinical Service Group/Department highlights risks associated with their service, which are then discussed at CRM. The risk register is routinely reviewed with leads with guidance and support provided regarding updates. Work is ongoing to review and improve this process and this will be discussed at OMT every month. An information Risk Register session was held with services on 27 September 2023 to ensure continuous improvement with the use of operational risk registers.

4.22 New risks identified on Datix are discussed at CRM. There is an ongoing review of the operational risk registers. At the time of reporting, there are 36

risks on the risk register, 1 of which is a new risk (since August 2023). These are monitored and reviewed as appropriate, by the service managers.

Duty of Candour

4.23 At the time of reporting there are no ongoing Duty of Candour incidents.

Items for escalation to the Clinical and Care Governance Committee

Learning Disability (LD) Team – Social Work Staffing

4.24 The LD Team, when fully staffed has 9.5 full time equivalent (FTE) Social Workers (SW's) and an Assistant Community Care Officer. The resource at the time of writing is 3.5 FTE SW's only, with one being newly qualified within the last 3 months.

4.25 There is 1 outstanding Advanced Practitioner (AP) vacancy with 1 AP vacancy having been recruited to, commencing in post in around 4 weeks' time. All vacant posts are continually re-advertised. The LD team has historically found challenges in recruitment, as LD is a specialist area with a high degree of intensity and complexity that does not appeal to all.

4.26 The current and anticipated staff resource in the coming weeks, is not sufficient to manage the complex cases held within the team, to manage all crises or meet all of the statutory duties. There is a real risk that those supported and their carers could come to harm due to an inability to respond to crises. If so, this could also lead to reputational damage to the team and to the partnership. Relationships will be tested with provider services because the team are unable to intervene when support is required with challenging situations. There could be increased delays in hospital discharges. Staff wellbeing is also a serious concern and the increased pressures on those remaining may lead to burn out, sickness and further vacancies.

Mitigations

4.27 As part of the vacancy management process there is increased scrutiny of all vacant posts. This is causing delays in the advertisement and recruitment process. Request to be made to the SMT, to expedite all LD staffing requests where existing funding is in place.

4.28 A request has been made to Locality Managers for other area teams to assist with some critical processes, such as Council Officer duties and the Screening of new ASP referrals. There has previously been an open dialogue with the Access Team for this and whilst they cannot assist immediately, they advised it will be reviewed on a week-by-week basis. Agreement has already been negotiated with the ASP team regarding the Council Officer rota with the LD team on reduced days.

4.29 To look for staffing resources that can be deployed from other areas or agency. Funding agreement has already been authorised for the use of agency staff via the Resource Management Group and team details have been submitted to a range of agencies.

4.30 The Team Manager will have oversight of all new referrals and current allocated cases and will provide direction with regard to prioritisation.

4.31 The team has created a separate risk register to monitor those people at high risk who SW cannot allocate immediately. This will be regularly reviewed and action taken as appropriate for prioritisation, allocation, interim support measures or for escalation.

4.32 LD health leads are to be advised of the situation. Health colleagues will already be working with some individuals and may be able to provide support, which reduces the need for SW support. It should be noted that it will likely create additional work for health colleagues.

4.33 A Social Worker currently manages the duty system. This task will be reassigned to the team administrators who will monitor calls and emails, and forward details to the manager or Social Workers for action. This will free up a Social Worker each day for other work.

4.34 As there are no advanced practitioners within the team, the practice consultants will be available for advice and support with social work practice issues within the team.

4.35 Communication will be made with those referring into the service for Social Work support, to inform that there are significant pressures in the service and that there will be an increase in response times.

Moray Integrated Drug and Alcohol Service (MIDAS)

4.36 As previously escalated to this Committee, on 25 May 2023 (para 9 of minute) and 31 August 2023 (para 7 of minute), due to lack of suitable clinical space, there remains ongoing issues which impact the service's ability to meet Medically Assisted Treatment (MAT) standards 4, 6, 9 and 10. These standards relate to harm reduction and psychological and mental health care. Representatives from the NHS Grampian Asset Management Team will be conducting a full market search to determine if there are any suitable sites for the team to move in to. Timeline for this is early 2024 once a scoping exercise has taken place with the team to identify the space that is needed.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"

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

(b) Policy and Legal

Clinical and Care Governance requirements are set out within the Moray Health and Social Care Integration Scheme. Appropriate arrangements

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

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

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

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

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

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

(e) Staffing Implications

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

(f) Property

None directly arising from this report.

(g) Equalities/Socio Economic Impact

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

(h) Climate Change and Biodiversity Impacts

None directly arising from this report.

(i) Directions

None directly arising from this report.

(j) Consultations

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

- HSCM CCGG members
- Sonya Duncan, Corporate Manager
- Caroline O'Connor, Committee Services Officer, Moray Council
- Fiona Robertson, Interim Chief Nurse Moray
- Tracy Stephen, Chief Social Work Officer
- Service Managers; Mental Health, Learning Disabilities, Public Dental Service

6. CONCLUSION

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

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

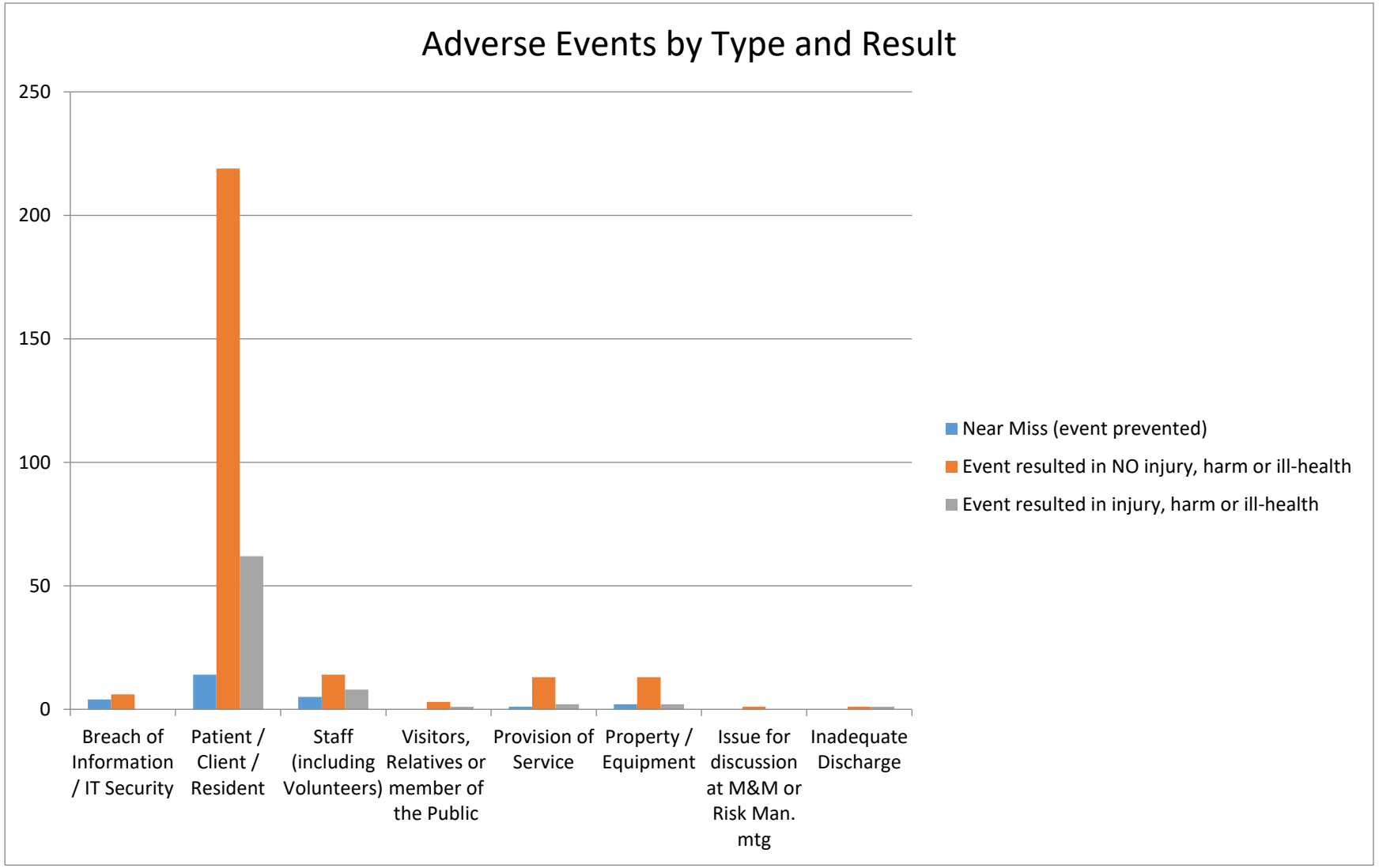
Ref:

APPENDIX 1

Adverse Events by Category and Level of Review Reported on Datix (Quarter 2, 2023/24)

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	Total
Abusive, violent, disruptive or self-harming behaviour	123	0	123
Access, Appointment, Admission, Transfer, Discharge (Including Absconders)	14	0	14
Accident (Including Falls, Exposure to Blood/Body Fluids, Asbestos, Heat, Radiation, Needlesticks or other hazards)	117	1	118
Clinical Assessment (Investigations, Images and Lab Tests)	2	0	2
Consent, Confidentiality or Communication	4	1	5
Financial loss	1	0	1
Implementation of care or ongoing monitoring/review (inc. pressure ulcers)	12	1	13
Infrastructure or resources (Staffing, Facilities, Environment, Lifts)	10	0	10
Medical device/equipment	2	0	2
Medication	23	1	24
Other - please specify in description	26	1	27
Patient Information (Records, Documents, Test Results, Scans)	7	0	7
Security (no longer contains fire)	1	0	1
Treatment, Procedure (Incl. Operations or Blood Transfusions etc.)	2	0	2
Total	344	5	349

Adverse Events by Type and Result Reported on Datix (Quarter 2, 2023/24)



Adverse Events by Service and Level of Review Reported on Datix (Quarter 2, 2023/24)

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	Total
Allied Health Professionals	16	0	16
Community Hospital Nursing	89	1	90
Community Nursing	6	1	7
Community Pharmacy	3	1	4
Community Therapy Services	1	0	1
General Practice	6	0	6
GMED	8	0	8
Mental Health - Adult Mental Health	120	0	120
Mental Health - Old Age Psychiatry	68	0	68
Mental Health - Specialisms	2	1	3
Primary Care	1	0	1
Public Dental Service	9	0	9
Refugee and Asylum Seekers	1	0	1
Vaccination Transformation Programme	14	1	15
Total	344	5	349

Adverse Events by Type and Severity Reported on Datix (Quarter 2, 2023/24)

	NEGLIGIBLE: Negligible/no injury or illness, negligible/no disruption to service, negligible/no financial loss	MINOR: Minor injury or illness, short term disruption to service, minor financial loss	MODERATE: Significant injury, externally reportable e.g. RIDDOR, some disruption to service, significant financial loss	Total
Breach of Information / IT Security	10	0	0	10
Patient / Client / Resident	240	49	6	295
Staff (including Volunteers)	21	6	0	27
Visitors, Relatives or member of the Public	3	1	0	4
Provision of Service	14	2	0	16
Property / Equipment	15	2	0	17
Issue for discussion at M&M or Risk Man. mtg	1	0	0	1
Inadequate Discharge	1	1	0	2
Total	305	61	6	372

All adverse events by result by Quarter on Datix

	2021/22 Quarter 2	2021/22 Quarter 3	2021/22 Quarter 4	2022.23 Quarter 1	2022/23 Quarter 2	2022/23 Quarter 3	2022/23 Quarter 4	2023/24 Quarter 1	**2023/24 Quarter 2**
Occurrence with NO injury, harm or ill-health	239	271	189	218	214	283	200	210	270
Occurrence resulting in injury, harm or ill-health	61	87	79	89	98	78	60	73	76
Near Miss (occurrence prevented)	37	25	31	29	40	38	20	22	26
Property damage or loss	0	0	0	0	0	0	0	0	0
Death	0	1	0	0	0	0	0	0	0
Total	**337**	**383**	**299**	**336**	**352**	**349**	**280**	**305**	**372**

Adverse Events by Severity Reported by Quarter on Datix

	2021/22 Quarter 2	2021/22 Quarter 3	2021/22 Quarter 4	2022/23 Quarter 1	2022/23 Quarter 2	2022/23 Quarter 3	2022/23 Quarter 4	2023/24 Quarter 1	**2023/24 Quarter 2**
Negligible	281	308	231	259	264	283	226	240	305
Minor	48	72	64	70	78	60	48	58	61
Moderate	8	2	2	4	8	5	6	5	6
Major	0	0	2	1	2	0	0	1	0
Extreme	0	1	0	2	0	1	0	1	0
Total	**337**	**383**	**299**	**336**	**352**	**349**	**280**	**305**	**372**

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 30 NOVEMBER 2023**

SUBJECT: **COMMUNITY OCCUPATIONAL THERAPY SERVICE**

BY: **OCCUPATIONAL THERAPY TEAM MANAGER**

1. REASON FOR REPORT

1.1 To inform the Committee that the waiting time for Occupational Therapy (OT) allocation is at a high level with people waiting far over the timescales for allocation and provide details on some of the ways the team are working to reduce waiting list times to a more acceptable level.

2. RECOMMENDATION

2.1 It is recommended that the Committee notes the Community OT team continue to work on reducing waiting times for allocation by improving and refining the service provided.

3. BACKGROUND

3.1 Health and Social Care Moray (HSCM) promotes and facilitates independent living for people who have a disability in their own home. Additionally, Moray Council has a statutory duty to provide assistance to make a house suitable for a disabled person, as far as is reasonably practicable. This is achieved by the provision of advice, rehabilitation and recommendation of equipment and adaptations. One method of providing appropriate equipment and adaptations is following an assessment from an Occupational Therapist (OT) or Occupational Therapy Assistant (OTA) from the Community OT service.

3.2 The Community OT Team accepts referrals regarding anyone who is a resident of Moray, has a disability and has an issue or difficulty with their activities of daily living. Information is received by the Access Team then passed to the Duty OT who investigates the situation further if needed and prioritises the case. The referral is then either allocated to a worker or placed on a waiting list. OTs tend to have an area (Forres, Elgin, Speyside, etc.) based around Social Work localities where they are allocated the majority of cases from.

3.3 A Community OT assessment usually involves observing a person in their own home whilst they are performing their daily activities with specific interest in any area of difficulty they are having. Once this functional assessment is completed, a plan is agreed with the person and progressed until the issue has been resolved or improved to a reasonably practical level. The service has an emphasis on minimising identified risk, 'needs-led' assessment and the provision and recommendation of essential equipment to allow interaction with life at home as well as to minimise risk to the person and involved carers. HSCM strive to deliver a service that is transparent, equitable and offer informed choice to the customer on both outcome and delivery of the service, under pinned by the principle of minimum intervention and best value.

3.4 Community OT has a wide responsibility and are called into a range of cases, providing input to children and adults and also are often called into and consulted about very complex situations. The team are passed cases from colleagues when a person needs a major adaptation to their property or Moving and Handling assessment and equipment.

3.5 Referrals are prioritised by a professional based on need and risk. The timescales the service aim for are:-

Critical priority for OT assessment – 2 weeks

Substantial priority for OT assessment – 8 weeks

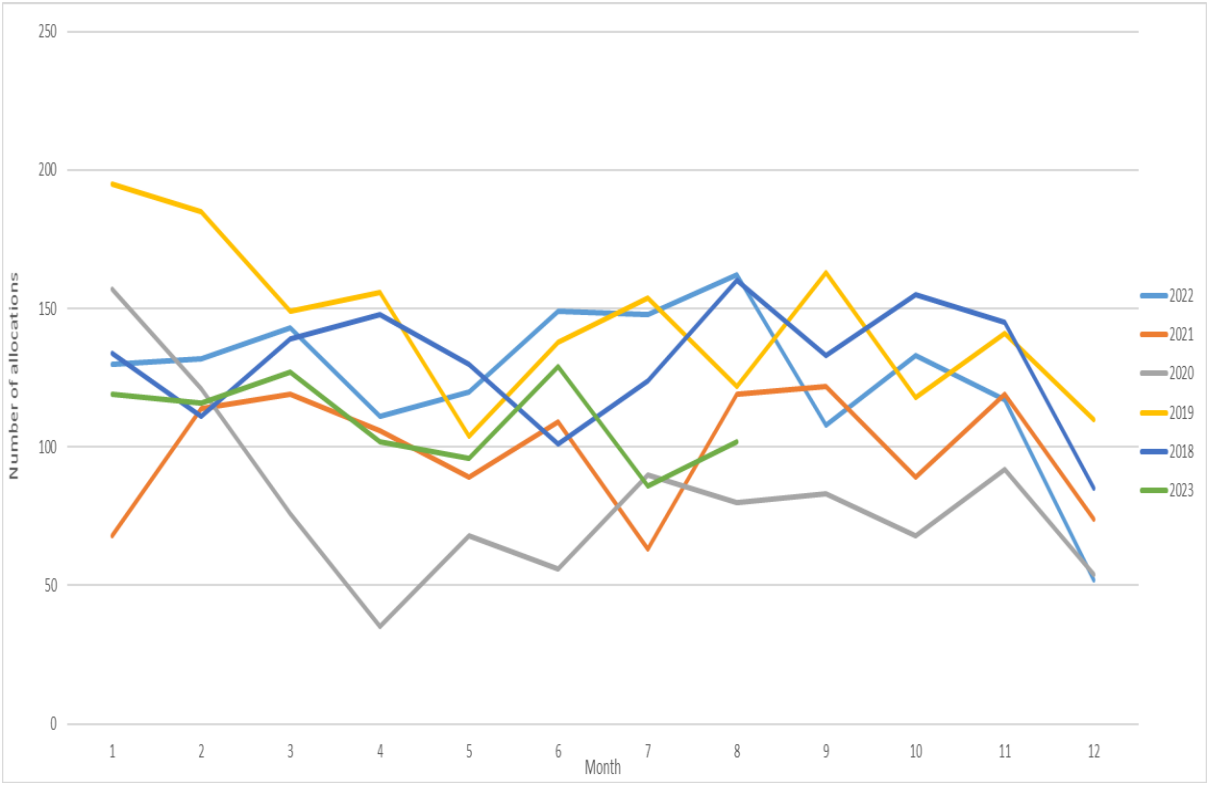
Moderate priority for OT assessment – 6 months

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Demand for service is high, at an average of 210 referrals per month in 2022-2023. The Waiting List for allocation of an OT increased substantially during COVID-19 to around 500 when there were restrictions on accessing clients. Once the service resumed, the waiting list began to fall however it has risen again over the past year. The Waiting List now stands at around 300 people with wait times over a year for Substantial cases and two years for Moderate. There has been an increase in the wait times for Critical cases, but the largest impact has been on the Moderate and Significant waiting lists. Due to our reduced capacity over the last year, OTs have been taking mainly Critical referrals, leading to a significant rise in the waiting times for the other lists. For context, the Waiting List was at high levels previously, in around 2016 it was around 500 and showed a steady decline until a low of under 100 in 2019.

OT allocations per year

4.2 This graph shows a breakdown of the amount of allocations the team has taken on per month for the last few years.



- The influence COVID had on the number of allocations starts in March 2020 and continues until 2022. During this period, although OT continued to provide input in Critical/Urgent situations, the Waiting List increased to around its current level.

- The team became understaffed in September 2022 and the effect this has can be identified in the number of allocations taken from that time to present.

- The stats for 2023 are in the middle range compared to previous years.

Rationalise Paperwork and Processes

4.3 A regular governance meeting with stakeholders from the adaptation process takes place regularly to review processes, problem solve potential issues and plan resources to encourage efficient workflow. From that meeting, the assessment process has been updated and the amount of systems that workers need to access to get the correct information has been reduced. Information systems have been reorganised to make data more accessible. The system to authorise and progress Major Adaptations has been updated to make it more robust and to give people more control and information earlier. A more efficient method of recording assessments, finding relevant information and progressing major adaptations will mean the number of allocations the team take on will increase.

Restructure

4.4 As recruitment to professional level posts has been difficult, HSCM have established Senior Occupational Therapy Assistants (SOTA) posts to work through the backlog of Level Access Shower Adaptations. The SOTA are responsible for cases that, although they are process driven, historically an OT would be allocated. SOTA are given support from professional staff to allow them to manage service users through these processes and their clinical decision making is closely supervised and authorised. The evidence here

shows that these two positions have processed a high number of cases since they started allowing OTs to concentrate on more complex work. This post has been identified as method of career progression and a way of retaining high skilled non degree qualified staff in the team. The SOTA post has worked well in these regards, but they are only funded until March 2024 so there is a risk that without these positions, waiting times for the above work will increase.

Staffing

4.5 Two new OTs have recently been successfully recruited (1.75 FTE) to work in the areas experiencing the longest delays. They are due to start in December 2023 and following a period of training and familiarising themselves to the role, they should start having an effect on the Waiting List numbers and times. There is still a vacancy for an OT of around 30 hours per week on a temporary contract as this has been difficult to recruit to. A full time OT should return from secondment in May 2024 however around this time, the SOTAs temporary contract will end.

Define the service

4.6 The Criteria for provision of OT Equipment and Adaptations is from 2018 and it would be beneficial to update it. This will mean a sharpening of criteria and potentially the Community OT team not providing assistance as they might have done before. Work is ongoing to review the parameters and scope of the service in consultation with other community teams, NHS teams and Social Work teams. In addition to this other localities are being consulted so that best practice and efficient models of service can be identified and adapted for use in Moray. Reducing the scope of the service and tightening up what Community OT can support with will reduce the high demand on the team. With other NHS Teams establishing their role in primary care and intensive rehab, Community OT could refocus on supporting the management of long term conditions, assisting with reviewing of packages of care and managing major adaptations. Work continues to improve communication between OT teams with local meetings to match a person's needs with the correct team being trialled.

Update Information

4.7 The information provided about the OT service should be updated and made available to the public in a range of forms. A project is underway with Digital Health and Innovation Scotland to develop an online OT site for information, self-management and signposting. Providing information in this way would increase transparency, improve individual's ability to self-manage and improve the publics' experience with the OT team.

Referral form

4.8 A continuing issue is the lack of information on referrals to Community OT meaning a worker has to contact referrers or clients to obtain information necessary to prioritise the case effectively. A new referral form has been developed which will provide enough information needed specifically for OT to make prioritising more efficient and accurate. This change will save time and provide a better experience for the client.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022 – 2032"

The continued service developments to reduce the waiting list for OT, have significant alignment to the themes of the Moray Integration Joint Board (MIJB) strategic plan and in particular to the Home First theme and the LOIP in supporting people to live independently within their community.

(b) Policy and Legal

Equipment and adaptations: guidance on provision (https://www.gov.scot/publications/guidance-provision-equipment-adaptations-2/documents/)

Private Sector Housing Disabled Adaptations Grants Policy

Policy for the Provision of Major Adaptations

Policy for the Provision of Occupational Therapy Equipment

(c) Financial implications

Timely OT input can reduce the burden on formal and informal carers and improve our client's independence in essential daily activities. The financial effects of not receiving OT intervention can often be seen in other areas of the system, with delayed discharges, avoidable hospital admissions, preventable Care Home placements and increases in formal care needs. As early and appropriate OT intervention can reduce the risk of these events occurring, it is a vital part of providing an efficient system of meeting peoples' needs in the community.

(d) Risk Implications and Mitigation

OT work is often based around reducing and minimising risk and whilst there is a lengthy wait for OT input people are at a level of an undesirable incident occurring. Long waiting times for OT service leads to people managing daily activities with an excessive risk of injury, increased dependence on services or family or the individual avoiding the task completely.

(e) Staffing Implications

There is a risk of staff burnout from high rate of complex, intensive and high pressured allocations. Staff also report difficulty building rapport or trust with people if they have been waiting a considerable time for service.

(f) Property

None arising directly from this report.

(g) Equalities/Socio Economic Impact

Not required as there is no change to policy.

(h) Climate Change and Biodiversity Impacts

None arising directly from this report.

(i) Directions
None arising directly from this report.

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

- HSCM Clinical and Care Governance Group members
- HSCM Operational Management Team
- Lesley Attridge, Locality Manager
- Sean Coady, Head of Service
- Caroline O'Connor, Committee Services Officer, Moray Council

6. CONCLUSION

6.1 Work needs to continue on bringing the Waiting List for OT input down to a more acceptable level. By completing the projects described above to further improve the service, alongside the resolution of staffing issues from the last year, the waiting list should show continued improvement over the next year.

Author of Report: Chris McLeod, Team Manager, OT
Background Papers: with author
Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 30 NOVEMBER 2023**

SUBJECT: **RECOMMENDED ALLOWANCES FOR KINSHIP AND FOSTER CARERS**

BY: **HEAD OF SERVICE AND CHIEF SOCIAL WORK OFFICER**

1. REASON FOR REPORT

1.1 This report informs the Committee of the recommended allowances for kinship and foster carers.

2. RECOMMENDATION

2.1 It is recommended that the Committee endorse the adoption of the proposals regarding the recommended allowances for kinship and foster carers.

3. BACKGROUND

3.1 Following the National Review of Care Allowances in September 2018, work has taken place between Convention of Scottish Local Authorities (COSLA) officers and Scottish Government to determine a Scottish Recommended Allowance (SRA) for kinship and foster carers, and 'Keeping the Promise' for Scotland's care experienced young people.

3.2 Further to this work, COSLA considered and approved a report in August 2023 supporting the introduction of a SRA for kinship and foster carers across all local authority areas.

3.3 Allowances are currently provided by all local authorities to eligible carers. However, this is decided at a local level and so varies across Scotland. The introduction of the SRA provides a recommended allowance that all local authorities must pay as a minimum, although they can also choose to pay more. This minimum level will be kept under review at a national level.

3.4 Where local authorities are already paying above the national minimum allowance, it is expected that this will continue so that eligible kinship or foster carers currently in receipt of the allowance will not suffer any detriment because of this commitment.

4. KEY MATTERS RELEVANT TO THE RECOMMENDATIONS

4.1 The SRA is intended to cover the cost of supporting a child such as clothing, food, after school activities. Although the policy of providing such allowances to foster and kinship carers is not new, and are provided by all local authorities, having a minimum national allowance is a new policy.

4.2 The Promise, and its Plan 21-24 make it clear that providing financial support to kinship and foster carers is a key element to ensuring that caregivers are best equipped to support and nurture children and young people they are looking after.

4.3 The Scottish Government has developed SRA rates based on independent analysis carried out by Fraser of Allander Institute in 2018. The cost of supporting a child, uprated on a similar basis as has been used for other payments to households, but also taking account of affordability and deliverability.

4.4 The Scottish Government has identified £16m funding to fund the introduction of the SRA from 2023/24. It has been modelled using current local authority expenditure on children in kinship and foster care, including 'informal' kinship care expenditure, and the most up to date data from the Children's Social Work Statistics 2021/22.

4.5 Like many local authorities, the Council currently use four age ranges (as shown in the table below) to differentiate the payment of allowances. The SRA uses three, effectively combining the 5-10 and 11-15 age ranges into one standard age bracket. When compared to the SRA, the rates in Moray are lower across the 0-10 and 16+ age range but higher for the 11-15 age range. Our current local rates compared to the SRA rates are outlined below:

Age	Current Moray Rates	Age	Scottish Recommended Allowance
Age 0-4	£142.86	Age 0-4	£168.31
Age 5-10	£162.73	Age 5-10	£195.81
Age 11-15	£202.58	Age 11-15	£195.81
Age 16+	£246.44	Age 16+	£268.41

4.6 The % comparison of the SRA in relation to current local rates is as follows:

Age	% comparison
Age 0-4	17.8% increase
Age 5-10	20.3% increase
Age 11-15	3.3% decrease
Age 16+	8.9% increase

4.7 To improve transparency of our local allowance framework, we propose reviewing our current allowance structure, with a view to aligning the local age ranges with the nationally applied ranges within the SRA. Any future proposals will continue to ensure no detriment where local allowances are already above the SRA. Specifically, it is proposed to maintain the current rate for 11-15

irrespective of this being above the SRA rate. This is in line with the recommendations from COSLA and the Scottish Government.

4.8 The additional cost of backdating eligible kinship and fostering allowances for those age groups where our local rate is currently lower than the SRA levels will be £133,900.06 for the full year 2023/24.

4.9 The £16m funding from the Scottish Government to support the implementation of the SRA is for the full 2023/24 financial year, as payments are expected to be backdated to 1 April 2023, and paid to eligible kinship and foster carers in a way determined by the local authority which best supports families.

4.10 Moray has been notified that it has been provided with £260,561 from the Scottish Government which provides sufficient provision for the additional costs of £133,900.06 for 2023/24.

4.11 The Scottish Government have committed to baselining the 2023/24 levels of support for the SRA allowances. A decision on the national mechanism for annual review and/or uprating of the SRA has yet to be taken by Scottish Ministers. It is understood that any proposal will be subject to national agreement through COSLA arrangements.

4.12 At this stage it is not possible to predict the allowances for 2023/24 and subsequent years. However, it is proposed that these allowances should be in line with those recommended by the SRA and that additional funding is made available. This is the same process currently in place for foster carer fees which are increased each year by the pay award percentage.

5. PROPOSALS

5.1 It is proposed that members of the Committee endorse the COSLA agreement to implement the new SRA for eligible kinship and foster carers across Moray.

5.2 It is further proposed that the Head of Service for Children & Families & Justice Social Work takes the necessary steps to implement the SRA, to back date any payments made from 1 April 2023 that have been below the SRA and to ensure that local rates continue to be reviewed as required to ensure all carers continue to receive at least the SRA.

5.3 It is further proposed that our annual review of payable allowances is transparent and that local rates remain appropriately aligned with the SRA. This will include a review of the current Council structure of allowances payable to eligible kinship and foster carers. The review would be undertaken as part of preparation for 2024/25 budget setting process and would need the commitment supported through COSLA to ensure no child's allowance is reduced as a result of the SRA implementation.

6. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Partners in Care 2022-2032"

The Corporate Plan 2024 makes a commitment to improving outcomes for Moray's most vulnerable young people and families and that more children will live with their families, being cared for in strong safe, communities across Moray.

(b) Policy and Legal

Following the National Review of Care Allowances in September 2018, work has taken place between COSLA officers and Scottish Government to determine a Scottish Recommended Allowance (SRA) for kinship and foster carers, and 'Keeping the Promise' for Scotland's care experienced young people.

Further to this work, COSLA considered and approved a report in August 2023 supporting the introduction of a Scottish Recommended Allowance for kinship and foster carers across all local authority areas.

It is proposed that our annual review of payable allowances is transparent and that local rates remain appropriately aligned with the SRA.

(c) Financial implications

Members are being asked to approve the recommendations in this report on the basis that there will be no net additional costs to the Council. The additional cost of backdating eligible kinship and fostering allowances for those age groups where our local rate is currently lower than the SRA levels will be £133,900.06 for the full year 2023/24. As noted, Scottish Government has set aside £16m nationally for the implementation of the SRA where Moray has been awarded £260,561 for 2023/24 which is sufficient to meet these in-year costs. On this basis, the proposal is cost neutral for Moray and the Children & Families & Justice Social Work 2023/24 revenue budget.

(d) Risk Implications and Mitigation

The financial risk implications and mitigations are outlined in section (c) above.

(e) Staffing Implications

There are no staffing implications.

(f) Property

There are no property implications.

(g) Equalities/Socio Economic Impact

Carers in Moray will suffer no financial detriment as a result of this change, the allowance that they receive will be comparable with those in other local authorities.

(h) Climate Change and Biodiversity Impacts
There are no climate change or biodiversity impacts.

(i) Directions
None.

(j) Consultations
Chief Officer, HSCM; Chief Social Work Officer & Head of Service; Head of HR, ICT and Organisational Development; Chief Financial Officer; Equal Opportunities Officer and Caroline O'Connor, Committee Services Officer have been consulted in the preparation of this report and are in agreement with the content relating to their areas of responsibility.

7. CONCLUSION

7.1 It is recommended that the Committee endorse the adoption of the proposals regarding the recommended allowances for kinship and foster carers.

Author of Report: Carl Campbell, Service Manager
Background Papers:
Ref: