Clinical and Care Governance Committee

Thursday, 23 February 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, 23 February 2023** at **14:00** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

SEDERUNT

Mr Derick Murray (Chair)
Dr Robert Lockhart (Chair)

Professor Siladitya Bhattacharya (Voting Member)
Councillor Peter Bloomfield (Voting Member)
Councillor Scott Lawrence (Voting Member)
Mr Graham Hilditch (Member)
Professor Duff Bruce (Member)
Ms Tracy Stephen (Member)

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

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

MINUTE OF MEETING OF THE CLINICAL AND CARE GOVERNANCE COMMITTEE

Thursday, 27 October 2022

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

PRESENT

Professor Siladitya Bhattacharya, Councillor Peter Bloomfield, Mr Simon Bokor-Ingram, Ms Sonya Duncan, Councillor Scott Lawrence, Mr Derick Murray, Ms Samantha Thomas

APOLOGIES

Mr Ivan Augustus, Mr Sean Coady, Ms Karen Donaldson, Ms Jane Ewen, Mr Graham Hilditch, Ms Deborah O'Shea, Mr Neil Strachan, Mrs Val Thatcher

IN ATTENDANCE

Also in attendance at the meeting were the Moray ASP Consultant Practitioner and Tracey Sutherland, Committee Services Officer.

1. Chair

The meeting was chaired by Mr Derick Murray.

2. Welcome and Apologies

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

3. Declarations of Member's Interests

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

4. Minute of Meeting of 25 August 2022

The minute of the meeting of 25 August 2022 was submitted and approved.

5. Action Log - 25 August 2022

The Action Log of the meeting for 25 August 2022 was discussed and updated.

6. Clinical and Care Governance Group Escalation Report - Quarter 2

A report by the Chief Nurse informed the Committee of progress and exceptions reported to the Clinical and Care Governance Group during quarter 2 of 2022/23 (1 July up to 30 September 2022).

Councillor Lawrence sought clarification on the admission criteria for the new Varis Flats in Forres. In response, the Chief Nurse confirmed that she would provide Councillor Lawrence with the information following the meeting.

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

7. Adult Support and Protection Multi Agency Improvement Plan

A report by the Consultant Practitioner, Moray Adult Support and Protection informed the Committee of the Adult Support and Protection (ASP) Multi-agency Improvement Plan in place following the recent joint inspection of ASP in the Moray partnership.

Following consideration the Committee agreed to note:

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

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

8. Clinical and Care Governance Progress Update

A report by the Chief Nurse provided an update to the Committee of the developments in relation to clinical and care governance and the intention to hold a further workshop.

Following consideration the Committee agreed to:

i) note the content of this report and the associated action plan (Appendix 1);

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

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

9. Complaints - Quarter 2 2022-23

A report by the Chief Nurse informed the Committee of complaint reported and closed during Quarter 2 (1 July 2022 to 30 September 2022).

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

10. Annual Complaints Report 2021-22

A report by the Chief Nurse provided the Committee with the Draft Health and Social Care Moray (HSCM) Annual Complaints Report for 2021/22.

Following consideration the Committee agreed to:

i) note the contents of the annual report; and

ii) submit the draft HSCM Annual Complaints Report to the Moray Integration Joint Board in November for approval prior to publication.

11. Drug Related Deaths in Moray

A report by the Interim Integrated Service Manager updated the Committee about Drug Related Deaths in Moray 2020, 2021 and into 2022.

Following consideration the Committee agreed to note:

i) the drug related death figures for Moray;

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

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

12. Strategic Risk Register

A report by the Chief Officer provided an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated on 17 October 2022.

Following consideration the Committee agreed to note:

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

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

MEETING OF MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE

THURSDAY 27 OCTOBER 2022

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY	UPDATE FEBRUARY 2023
1.	Clinical and Care Governance Group Escalation	Information on the admission criteria for Varis Flats to be provided to members of the Committee		Chief Nurse	

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL CARE GOVERNANCE COMMITTEE ON 23 FEBRUARY 2023**

SUBJECT: **STRATEGIC RISK REGISTER – JANUARY 2023**

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 January 2023.

2. RECOMMENDATION

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

i) the updated Strategic Risk Register included in APPENDIX 1; and

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

3. BACKGROUND

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

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

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

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

4. KEY MATTERS RELEVANT TO RECOMMENDATION

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

4.2 The return to 'business as usual' from the Covid-19 pandemic continues. However, there has not been any relief in the system, and it continues to challenge and 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 Governance, adverse events and risk will be covered as part of a Clinical Governance workstream in upcoming workshops, commencing January 2023.

4.6 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.

4.7 Recruitment and retention continues to provide challenges across all disciplines. The Moray Health and Social Care Workforce Plan was approved by MIJB on 29 Sep 2022 (section 12 minute refers to). Over the next three years, the workforce plan will focus on the five key areas known as 'pillars'; they include, Plan, Attract, Train, Employ and Nurture staff. A report discussing the challenges and plans of Recruitment and Retention was presented to MIJB on 26 January 2023.

4.8 As part of the ongoing work to ensure all patients are treated in 'the right place, at the right time', HSCM Senior Clinical Leads led two days of audit across Moray. The findings will be used to further develop plans across Moray.

4.9 The possibility of planned power outages raised by SSEN. Civil contingency groups are discussing options and reviewing Business Continuity Plans to ensure planning is underway. Additional support has also been funded by HSCM to assist Primary Care planning.

4.10 There continues to be significant financial risk in the system. The 2021-22 audited financial accounts were signed off by MIJB 26 January 2023. It was noted that the full impact of the clawback of the Covid reserve is not yet quantifiable. A further update will be presented to MIJB in March 2023.

4.11 There continues a significant number of hours per week of unmet need for care at home, with little change in these figures this year. There is an urgent need to increase supply to support the Health and Social Care system. Regular meetings and action plans continue to take place to support teams.

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

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 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 the Senior Management Team and presented to Clinical and Care Governance Group.

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 revised and updated version of the Strategic Risk Register.

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

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT 23 January 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	**INCREASING** ↑
Rationale for Risk Rating:	The strategic plan "Partners in Care" 2019 to 2029 was developed and launched in December 2022. Membership of IJB committees has recently changed due to the elections in May. An amendment to the Scheme to increase membership by one from each of the partner organisations was ratified in March 2022 by the Scottish Government following due process and approval by Moray Council and NHS Grampian Board. During the initial Covid 19 response, normal business was suspended and emergency arrangements were implemented. IJB, CCG and APR meetings restarted during August 2020. Weekly meetings were instigated with Chair/Vice Chair and Chief Officer and these continue. A delivery plan for the new Strategic Plan "Partners in Care" 2019 to 2029 which will be presented early 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" 2019 to 2029 • Governance arrangements formally documented and approved by MIJB January 2021. • Agreed risk appetite statement. • Performance reporting mechanisms. • Consultation with legal representative for all reports to committees and attendance at committee for key reports. • Standing orders have been reissued to all members	
Mitigating Actions:	Induction sessions were held for new IJB members after May elections. Further sessions will be arranged for recent appointees. IJB member briefings are held regularly as development sessions. Conduct and Standards training held for IJB Members in June 2022 provided by Legal Services.	

	SMT regular meetings and directing managers and teams to focus on priorities. Regular development sessions held with IJB and System Leadership Group Strategic Plan and locality management structure is in place The work that has been progressed through the Covid19 response has escalated developments in some areas as a matter of priority. This has been achieved through collaborative working with partner organisations and the third sector.
Assurances:	• Audit, Performance and Risk Committee oversight and scrutiny. • Internal Audit function and Reporting • Reporting to Board. • The Moray Transformation Board has recently recommenced and will support an oversight of planned business across HSCM.
Gaps in assurance:	Work is underway on the refresh of the Strategic delivery plan and will incorporate the work being taken forward for Self-Directed support, Hospital at Home and , Locality Planning. A delivery plan is being developed alongside the refreshed Strategic Plan.
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. . These groups have now recently recommenced following the pause during the Covid19 response. The interim Strategy and Planning Lead is now taking this forward and prioritising and focusing on strategic planning and priorities over the short and longer term.

2		
Description of Risk: *Financial*	There is a risk of MIJB financial failure in that the demand for services outstrips available financial resources. Financial pressures being experienced both by the funding Partners and Community Planning Partners will directly impact on decision making and prioritisation of MIJB.	
Lead:	Chief Officer/Chief Financial Officer	
Risk Rating:	Low/ medium/ high/ very high	**VERY HIGH**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**

Rationale for Risk Rating:	Whilst the 2020/21 to 2022/23 settlement saw additional investment for health and social care that was passed through to the MIJB, there remains a significant pressure due to the recurring core overspend, since most of the new investment related to new commitments. Financial settlements are set to continue on a one year only basis, which does not support sound financial planning. In addition, many uncertainties have arisen relating to the carried forward ear marked reserves with the clawback of the Covid reserve and reduction of the PSIF funding in 2022/23 as well as other funding being looked at. The full impact is not yet quantifiable. The Revenue Budget 2022/23 was approved by MIJB on 31 March 2022 as a balanced budget. A small savings plan of £0.11 million was approved and achieved. Additional Scottish Government investment is provided again for 2022/23, this is to meet additional policy commitments in respect of adult social care pay uplift for externally provided services and seeks to ensure that capacity can be maximised and ensuring system flow. The final outturn position will be finalised and reported to the MIJB in June where it is anticipated there will be a small ear marked reserve. The update medium Term Financial Framework was presented as part of the budget papers on the 31st March 2022 however, it is imperative that this is further reviewed during the 2022/23 year to ensure alignment with the upcoming revisions to the Strategic Plan and is planned to be presented to MIJB on 30 March 2023.
Rationale for Risk Appetite:	The Board recognises the financial constraints all partners are working within. While we are cautious and open about accepting financial risks this will be done: • Where a clear business case or rationale exists for exposing ourselves to the financial risk • Where we can protect the long term sustainability of health & social care in Moray The Covid-19 recovery continues to place risk on the MIJB finances as we continue through the, recover and transform stages. Whilst we are now officially in the recovery phase there has been no change in the pressures felt by the system..
Controls:	There is an interim arrangement for CFO cover from Moray Council. Permanent recruitment efforts have not been successful. The Chief Officer is working with both the Council and NHS Finance Leads to secure a longer term interim arrangement. The CFO and Senior Management Team have worked together to address further savings which will be presented to the Board for approval as part of the budget setting procedures for 2022/23. This should be a focus of continuous review to ensure any investment is made taking cognisance of existing budget pressures. A revised Financial Framework was presented to the MIJB on 31 March 2022, and a further review will take place once the current strategic plan has been reviewed to assure alignment.
Mitigating Actions:	Risk remains of the challenge that the MIJB can deliver transformation and efficiencies at the pace required whilst dealing with the pressures that are emerging as a result of the pandemic. Financial information is reported regularly to both the MIJB, Senior Management Team and System Leadership Group.

	The Chief Officer and Chief Financial Officer (CFO) continue to engage in finance discussions with key personnel of both NHS Grampian and Moray Council. These conversations have continued throughout the pandemic phase. Chief Officer and CFO will continue to engage with the partner organisations in respect of the financial position throughout the year. Cross partnership performance meetings are in with partner CEOs, Finance Directors and the Chair/Vice Chair of the MIJB.
Assurances:	MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.
Gaps in assurance:	None known
Current performance:	An overspend of £1,454,162 was reported to the IJB at 30 Sept 2022. The Scottish Government have announced their intention to reclaim surplus Covid reserves, £6,239,000 is due to be clawed back in January 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 the potential for staff industrial action.

3		
Description of Risk: *Human Resources (People):*	Inability to recruit and retain qualified and experienced staff to provide and maintain sustainable, safe care, whilst ensuring staff are fully able to manage change resulting from response to external factors such as the impact of Covid and the actions that arose from the recommendations from the Independent Review of Adult Social Care 2021.	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**HIGH**

Risk Movement:	Increase/ decrease/ no change	**INCREASING**
Rationale for Risk Rating:	There continues to be issues with recruitment to front line services that require specific skills and experience. This has been the case for some time now and continues to place pressure on existing staff. Allied Health Professions, Social Work 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 has reduced during the period. The various impacts of Covid-19 has placed a significant strain on the Partnerships resources across frontline and support functions and this has resulted in delays for the progress of projects relating to the achievement of strategic objectives. HSCM is currently has approximately 70 fixed term or seconded posts which can create long term instability for teams. This is being reviewed by the Senior Management Team. The Care Homes in Moray also face difficulties with recruitment and retention of staff to care at home roles in particular is still being experienced. Efforts are being made to provide support but the situation remains challenging. The transition from EU membership has not presented any specific concerns for workforce and this will continue to be monitored. The impact of forthcoming budget allocations and the withdrawal of all Covid funding will also mean that HSCM will face some challenging 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 for Health and Social Care Moray (HSCM), such as ICT, HR, Legal and design.	
Rationale for Risk Appetite:	Safety risks that could result in harm to service users, staff or the public are inherent in Health & Social Care services. The safety of individuals is paramount therefore standards of safety management and clinical care have to be high, and the Board will continue to seek assurances this is the case. The Board's ambition is for health & social care to be people centred. This means supporting people in decision making about their own health & care, which may expose individuals to higher risk where they make an informed decision. The Board will also seek to balance individual safety risks with collective safety risks to the community.	
Controls:	Management structure in place with updates reported to the MIJB. Organisational Development plan in place and Workforce Plans are being updated to align to the new strategic plan. Continued activity to address specific recruitment and retention issues. Management competencies continue to be developed through Kings Fund training although this was suspended due to Covid19.	

	Communications & Engagement Strategy was approved in November 2019 and is being implemented. Council and NHS performance systems in operation with HSCM reporting being further developed and information relating to vacancies, turnover and staff absences is integral to this. Managers are highlighting any areas of concern and where appropriate this is identified in operational risk registers. HSCM services have commenced weekly reporting of workforce sit reps for Senior Management Team oversight highlighting vacancies, annual leave, sickness absence and Covid impacts so that issues can be identified and assessed quickly.
Mitigating Actions:	System re-design and transformation. Organisational Development Plan and Workforce plan were updated and approved by MIJB in November 2019. The updated Workforce plan has been submitted to Scottish Government and comments were received by the HSCP in October 2022. These are currently being worked through. These plans are core documents for the Workforce Forum which has recently re-commenced following a temporary suspension during the first quarter of this year due to Covid impact. Staff Wellbeing is a key focus and there are many initiatives being made available to all staff including training, support, information and access to activities. Locality Managers are developing the Multi-disciplinary teams in their areas and some project officer support has been provided to develop the locality planning model across Moray. Lead Managers are involved in regional and national initiatives to ensure all learning is adopted to improve this position. Lead Managers and Professional Leads are linked to University Planning for intakes and programmes for future workforce development.
Assurances:	Operational oversight by Moray Workforce Forum has resumed and will report to MIJB in accordance with the agreed Governance framework. The HSCM Response Group was in place over the whole period of the Covid19 pandemic providing focussed leadership around emerging issues and resolving them. This group stood up again in April and is meeting daily whilst the system is pressured, this will be reviewed as the situation evolves. The Heads of Service are co-ordinating and escalate to SMT where necessary. These meetings have been increased as service needs dictate.
Gaps in assurance:	Further work required to develop workforce plans to reflect strategic plan implementation programmes..
Current performance:	The IMatter survey results for 2022 were received by managers for review and action plans. Preparatory work is commencing on the action plans for iMatter 2023. 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:	Locality planning assessed as medium in relation to ability to work at the pace required and current workforce capacity. Performance framework to be further developed from a planning perspective to show the links through operational service delivery to strategic objectives. Recent engagement with individuals representing their communities or third sector organisations in a variety of forums is highlighting that problems with their capacity to fulfil our needs so more co-ordination and clearer focus is required to ensure that the communication, engagement and outcomes are meeting identified needs.
Rationale for Risk Appetite:	The Board is cautious but open about risks that could damage relationships with different stakeholders. It recognises many of our aspirations depend on effective collaboration, coproduction and partnership working with a range of stakeholders. The appetite also recognises that while the aspiration is to be a co-operative partner, some partners will not be able to move at the same pace as us all the time. We will seek to protect relationships in the long term and will not set out to antagonise stakeholders deliberately. For example, we must not be seen to exclude or prevent participation in the design of services where there is an appetite to do this. We must be mindful that repairing relationships is easier when there is already a well of goodwill to draw on, and that further damage to an already damaged relationship will not be conducive to good long term outcomes.
Controls:	Governance Framework approved by IJB January 2021 Communication and Engagement Strategy approved November 2019 Annual Governance statement produced as part of the Annual Accounts 2021/22 and submitted to External Audit. Annual Performance Report for 2021/22 was published in November 2022. Performance reporting mechanisms in place and being further developed through performance support team, home first group and system leadership team. Community engagement in place for key projects areas such as Forres, Keith and Lossiemouth with information being made available to stakeholders and the wider public via HSCM website. Participation of stakeholders in a variety of meetings such as Home First project, carer strategy, Strategic, Planning and Commissioning groups.
Mitigating Actions:	Schedule of Committee meetings and development days in place and implemented. Good working relationship established with Audit Scotland, the MIJB's appointed external auditors since 2016/17. Discussions at leadership meetings to ensure all standards are being met around Public Sector Equality Duty and published where appropriate. There is a new programme of training to ensure all policies are Equalities Impact Assessed and the findings are published.

	Annual Performance Report for 2022/23 will be published in July 2023 after being presented to the IJB in June 2023. Social media is actively used as a method of engaging with the public, with short videos focussing on particular services being trialled. SMT have considered the existing arrangements for engagement with stakeholders and work is being undertaken to align our framework with the Scottish Government "Planning with people guidance" and ensure that mechanisms are in place across services to evidence and evaluate their impact.
Assurances:	Oversight and scrutiny by Clinical and Care Governance Committee, Audit Performance and Risk Committee and MIJB. Summary reports of minutes of MIJB meetings are submitted to Council committee and NHS Board.
Gaps in assurance:	Progress on implementation of the Communication and Engagement Strategy has been impacted by the Covid 19. Due to the impact of COVID and requirement for social distancing the normal mechanism for engagement were not all available. More use is being made of social media and Microsoft teams and other options and methods for engagement with staff are being used via NHSG such as videos on YouTube and one question surveys. Going forward there may be more opportunity for face to face meetings to take place again but it should be considered that this will not be beneficial for all. It is anticipated that once a Communication and Engagement Officer and supporting role are recruited.that this work stream will rapidly restart as a priority.
Current performance:	Communications Strategy was reviewed approved by IJB November 2019. Annual Performance Report 2021/22 published November 2022. Audited Accounts for 2021/22 were audited and approved in January 2023 and will be published in February 2023. Due to Covid19 there have been increased levels of briefings to staff, the public and Chair/Vice Chair of MIJB with a focus on the key elements of the response.
Comments:	A communication cell was established as part of the Local Resilience Partnership Covid and storms response with representation from Councils, HSCP and NHSG. This was led by Aberdeen City Council and was an example of the collaborative working that took place. This forum provides assurance that messages to all stakeholders are consistent. There has been representation from the Home first project at the Wellbeing forum to facilitate sharing of information and seeking views.

5		
Description of Risk: *Environmental:*	Inability to cope with unforeseen external emergencies or incidents as a result of inadequate emergency and resilience planning.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Due to the response requirements for Covid 19 progress has been made in a number of areas. SMOC information is updated, control room guidance updated and expanded, control centre protocols were implemented and remain in place and management teams have responded in an agile, responsive and collaborative way under very challenging conditions. Teams continue to do their best but there are areas where they still feeling overwhelmed and service delivery is challenging. With effect from March 2021 MIJB is defined as a Category 1 responder under the Civil Contingencies (Scotland) Act and there are additional requirements for preparedness that is being taken forward in partnership with NHSG and Moray Council emergency planners.	
Rationale for Risk Appetite:	The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act and the Category 1 status applied in March 2021, and work with partner organisations to meet these obligations	
Controls:	Winter Preparedness Plan was updated (but not tested as in previous years) alongside NHSG plans as NHSG implemented their crisis management framework which required participation of partners at Daily connect meetings to discuss and prioritise resource to address issues with system flow. HSCM Civil Contingencies group established and meeting regularly to address priority subjects. NHS Grampian Resilience Standards Action Plan approved (3 year). Business Continuity Plans in place for some services although overdue a review in some areas. Knowledge of critical functions and ability to respond quickly and effectively has been in evidence during incidents such as Gas outages in Keith (January and February 2021) and Covid response, Storms (Arwen, Malik and Corrie) – debriefs carried out and learning identified. A Resilience Newsletter started in December 2022 to ensure all staff receive some personal resilience information together with resources for teams to plan. Regular updates to SMT and SLG regarding potential power outages across the country. Regular system wide meetings to discuss potential Industrial Action implications and service planning. A review of the Festive season arrangements has commenced and will conclude in February 2023.	

Mitigating Actions:	Information from the updated BIA/BCP informed elements of the Winter Preparedness Plan A Friday huddle is in place which gathers the status of services across the whole system to provide information and contact details to the Senior Manager on Call (SMOC) over the weekend. 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. Practitioner group established for Moray with representation from HSCM, Dr Grays, Moray Council and NHSG to discuss matters arising from the Local Resilience Forum and within our respective organisations. In addition it will provide a forum for discussion of the linkages between organisational response plans to ensure there are no gaps or over reliance on particular local resources. HSCM continues to monitor the local situation regarding impacts on staffing and is engaged with NHSG emergency planning arrangements and Council Response and Recovery management team to be ready to escalate response if required. Work was undertaken within NHSG, Aberdeenshire HSCP and Aberdeen City HSCP to look at Surge flows and establish a mechanism that will provide easy identification of “hot spots” across the whole system in Grampian, to facilitate a collaborative approach to addressing the issues through the use of a common Operational Pressure Escalation approach. This work could underpin surge responses in winter and at other times of pressure and having a standard approach across Grampian could aid communication and understanding.
Assurances:	Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny. HSCM Civil Contingencies group review specific risks and action plans to mitigate, developing plans and testing arrangements in partnership with NHSG and Council
Gaps in assurance:	Moray Integrated Joint Board (MIJB) was designated as a 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.

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

	The debriefs from the storms in 2021/22 have identified lessons learnt for Grampian Local Resilience Partnership and more locally for the response co-ordination within Moray. Action plans are being developed in collaboration with Moray Council's emergency planning officer to address the issues identified. The main issues related to developing wider awareness of roles and responsibilities, and improving general awareness of response structures and meeting protocols. This will be incorporated into training schedules going forward. It has also highlighted the need for a robust arrangement for out of hours contact and clarity of roles and responsibilities across the system which is being discussed at SMT. Option Appraisal discussions 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. Due on ongoing system pressures and staff vacancies the draft strategy document 'Care for People' document and associated response structures has been completed and is awaiting sign off by Senior Management involved, before being presented to SMT, OMT and IJB. It is anticipated this will be completed by end February 2023., A draft operational response plan has been drawn up and will also be presented for approval shortly after. The intention is to hold a table top exercise with managers from HSCM and Moray Council to test the invocation arrangements to ensure common understanding of roles and responsibilities. Table top style exercises are currently being arranged with some of those services who have submitted their finalised plans for February 2023.
Current performance:	The Senior Management Team participated in Strategic Leadership in a Crisis training in 2020 and a programme of further training for the wider management team is scheduled. A follow up session was held in September 2022. 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 reviewed by APR committee on 31 March 2022. Report on the implications of the designation as a Category 1 responder was presented to MIJB 25 November 2021.

	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. It is also planned to provide additional resource to ensure our Primary Care partners are informed and engaged in the process.
Comments:	The requirements of a Category 1 Responder continue to increase in demand placing increased pressures across already overstretched services and managers. MIJB does not have a subject matter expert leading on these topics.

6		
Description of Risk: *Regulatory*	Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**INCREASING** ↑
Rationale for Risk Rating:	Considered medium risk due to the impact of Covid-19 and resultant efforts required to remobilise services and/or the increase in workloads stretching a workforce that has been under sustained pressure for a considerable time. The ongoing impact of the Covid 19 pandemic is stretching resources to deliver care in the community across all providers (internal and external) so there is a potential increased risk of expected standards not being achieved despite the best efforts of all concerned.	
Rationale for Risk Appetite:	The Board, staff and providers across Moray are all committed to ensuring high standards of clinical care & governance through operational policies. Innovation and new ways of working may mean traditional regulations do not exist and require to be developed, no longer apply, or are contradictory. We will only take regulatory risks knowingly, following consultation with the relevant regulatory body and where we have clear risk mitigation in place.	
Controls:	Clinical and Care Governance (CCG) Committee established and future reporting requirements identified Clinical Risk Management and Practice Governance group has oversight of their respective professional standards and feed into Clinical and Care Governance Group, which then escalates to CCG Committee as necessary. High and Very High operational risks are reviewed by System Leadership Group monthly and a review of all risks will be undertaken as part of the risk management framework. A workshop took place in January 2023, 'A conversation about Clinical Governance'. This will be followed by 3 more workshops in 2023. Complaints and compliments procedures in place and monitored. A review of the current complaints processes in HSCM is being undertaken and information will be shared at one of three planned clinical governance workshops early 2023. Clinical incidents and risks are being reviewed on a weekly basis to ensure processes are followed appropriately and consistently and responses are recorded in a timely manner. Adverse events and duty of candour procedures in place and being actioned where appropriate and summary reports submitted to CCG committee.	

	Reports from external inspections reported to appropriate operational groups and by exception to SMT for subsequent reporting to CCG or Audit Performance and Risk Committee as appropriate, albeit there has been a reduction in some areas of external inspection reporting during the Covid period due to social distancing restrictions Care Home Oversight Group meets to oversee and manage risks in care homes. Children and Adult Protection services are being delivered and reported to their respective committee on a regular basis.
Mitigating Actions:	This risk is discussed regularly by the three North East Chief Officers. Additional resource has been allocated to support the analysis of information for presentation to CCG committee All High and Very High risks are now brought before the senior management team in Moray. Process for sign off and monitoring actions arising from Internal and External audits has been agreed
Assurances:	Audit, Performance and Risk and Clinical and Care Governance Sub-Committees oversight and scrutiny. Governance Framework in place and operational.
Gaps in assurance:	Process for highlighting recurring themes or strategic expectations from external inspections requires further development to ensure Committee has sight of significant issues. The vacancy of clinical governance co-ordinator has now been appointed to and this will be part of their work programme.
Current performance:	External inspection reports are reviewed and actions arising are allocated to officers for taking forward. Two Days of Audit took place across Moray on 25th and 26th January, 2023 respectively. These were led by the Clinical Service Leads. Any shared learning will be disseminated through the correct channels. A summary of inspections is included in the Annual Performance report. The level is marked as an increasing risk on the basis that services are under pressure with the issues with staffing capacity and the need to focus on delivery of critical functions which may mean external inspection are not the priority at this moment in time. The Adult Support Protection inspection took place in April/May and an action plan has been developed and is now in place.
Comments:	No major concerns have been identified for HSCM services in any audits or inspections during 2021/22.

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

	NHSG but being developed locally to identify the triggers and resultant actions required in services to respond to pressure points.
Mitigating Actions:	Service managers monitor performance regularly with their teams and escalate any issues to the System Leadership Group (SLG) for further discussion to provide wider support, developing shared ownership and a greater understanding across the whole system. Key operational performance data is collated and circulated daily to all managers. A Daily dashboard is held on illuminate for managers to access to ensure any potential issues are identified quickly so action can be taken. This dashboard is being reviewed and will be further developed with the intention of further dashboards to provide a whole system overview. This has been discussed at SLG and agreed. Performance information is presented to the Performance sub group of Practice Governance Group to inform Social Care managers of the trends in service demands so that resources can be allocated appropriately.
Assurances:	Audit, Performance and Risk Committee oversight. Operationally managed by service managers, summary reports to Practice Governance and clinical and care governance group and to System Leadership Group. Strategic direction provided by Senior Management Team. HSCM Response Group continues to meet and reviews the key performance information and actions that are required to deliver the priority services.
Gaps in assurance:	Development work in performance to establish clear links to describe the changes proposed by actions identified in the Strategic Plan has recommenced but is at an early stage. This will be progressed as the revised outcomes are determined and associated KPI are identified. Progress will be reported to future Board meetings. 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:	The Covid19 pandemic impacted on all areas of the service and work is underway to take the learning and experience gained during the response to collate performance information in dashboards to support mangers interpret the impact of Covid19 on their services, now and going forward. There are likely to be changes to ways of working and this may also have impact on the performance information required.
Comments:	Locality profile information has been provided to Locality Steering Group/Locality Manager to inform potential priorities for consideration in Localities and work will be taken forward regarding development of performance monitoring and reporting of key performance indicators in relation to Localities once it has been determined what the intended outcomes are. Locality plans will be presented to the IJB early 2023.

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

8		
Description of Risk: *Transformation*	Inability to progress with delivery of Strategic Objectives and Transformation projects.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	There are many issues that will impact on the ability to progress to deliver Strategic Objectives. The Strategic Planning & Commissioning group has been refreshed and re-launched and key work is being progressed. There was an initial meeting held on 22 September 2021 to consider terms of reference and the proposed structure for oversight, prioritisation and assurance in relation to key developments, their fit with IJB strategy and enabling elements. The interim appointment of the Strategic and Planning Lead provides capacity to take this forward and to align the priorities arising nationally, Grampian-wide and locally. The remobilisation plan for HSCM services that were suspended or reduced is progressing with Providers services and social work implementing the IJB decision to return to delivery of both substantial and critical eligibility criteria. Work has progressed risk assessments are completed and assessments have been or are in the process of being reviewed to ensure equality.	

	The impact of Covid 19 on the population of Moray is still not fully realised. It is therefore not possible to predict the extent of the impact on the ability to progress with delivery of Strategic Objectives. There are some aspects that have progressed very well such as introduction of Near Me consultations but there are others that are more difficult to progress. There is concern that due to the workloads and challenges over the last year that teams are weary and/or do not have capacity at this moment in time, to progress with delivery of development plans at this moment in time. In addition the pandemic is still present in the community so services are still responding to the impacts it has for the population of Moray. Managers are working with teams to establish "readiness" and their capacity and sense of wellbeing and the collated output will inform plans going forward. One key aspect to facilitate transformation is the need for progress in relation to ICT infrastructure, data sharing and data security across the whole system. Work was undertaken by NHS Grampian and partners to address the needs for ICT kit and information during the response to Covid.
Rationale for Risk Appetite:	The Board has a high appetite for risks associated with delivery of transformational redesign. The following should be considered when accepting these risks: • We understand and can mitigate other risk types that may arise, e.g. safety or financial within appetite • Service users are consulted and informed of changes in an open & transparent way • We will monitor the outcome and change course if necessary
Controls:	It is recognised that there will be significant changes taking place in Social Work practice with the implementation of the Self Directed Support standards and the move to outcomes based services, so governance arrangements are being set up to facilitate the same type of oversight and communication that is in place for the Home First programme.
Mitigating Actions:	Integrated Infrastructure Group previously established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters which is an area that will be taken forward alongside the Moray Growth Deal projects. 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.
Gaps in assurance:	Transformation/implementation planning is in development and will inform outcomes and performance reporting on the delivery of the strategic plan. Protocol for access to systems by employees of partner bodies are in place. Information Management arrangements to be developed and endorsed by MIJB.

	Process of identification of issue and submission to data sharing group requires to be reinforced to ensure matters are progressed. 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.
Current performance:	Training programme to be developed on records management, data protection and related issues for staff working across and between partners.
Comments:	Where national systems are involved it may not be possible to identify a solution however the issues will be able to be raised at the appropriate level via the Grampian Data Sharing Group where all three partnerships are represented.

9		
Description of Risk: *Infrastructure*	Requirements for support services are not prioritised by NHS Grampian and Moray Council.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Changes to processes and necessary stakeholder buy-in still bedding in. Moray Council is undertaking a Property review of office and depot accommodation and the potential impact for HSCM services requires consideration. The output was anticipated in October 2019 however due to changes with roles and responsibilities within the Council however the paper has been out for consultation. NHSG have advised that staff should continue to work from home at present whilst policies and protocols are developed. Moray Council have a dedicated MC officer leading on a hybrid working plan with input from HSCM on their requirements. It is anticipated that this might conclude end 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. The impact of Covid has resulted in a change in ICT strategy for Moray Council. Council employed staff requiring mobile technology have now been provided with it and some staff are still working from home.	
Rationale for Risk Appetite:	Low tolerance in relation to not meeting requirements.	
Controls:	Chief Officer has regular meetings with partners Computer Use Policies and HR policies in place for NHS and Moray Council and staff. PSN accreditation secured by Moray Council Infrastructure Programme Board was established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT. Process for submission of projects to the infrastructure board approved and implemented to ensure appropriate oversight of all projects underway in HSCM. The Board 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 Dr Gray's strategy (vision for the future) is being produced collaboratively with input from NHSG and HSCM management.
Assurances:	Infrastructure Programme Board functions to provide robust governance and assurance that proposed projects have a robust business case and meets requirements of the respective partner organisations. This board reports to Strategic Planning and Commissioning Group. Both of these groups 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 may take longer. Recruitment for vacancies takes considerable time due to various factors and is presenting a strain on services to maintain normal service whilst covering vacancies. There have been several posts that have had to go out to advert more than once extending the time other staff are covering gaps.
Current performance:	No update.
Comments:	Existing projects will be reviewed as part of the development of the transformation plans for the Strategic Plan to ensure resources are being dedicated appropriately and aligned to the emerging Strategic priorities. Our requirements for support will be communicated via appropriate channels

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 23 FEBRUARY 2023**

SUBJECT: **COMPLAINTS REPORT FOR QUARTER 3, 2022/2023**

BY: **CHIEF NURSE, MORAY**

1. REASON FOR REPORT

1.1. To inform the Committee of complaints reported and closed during Quarter 3 (1 October 2022 – 31 December 2022).

2. RECOMMENDATION

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

3. BACKGROUND

3.1. Within 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 Local Authority, which complies with the SPSO's guidance on a model complaints handling procedure and meets all of the requirements of the Patient Rights (Scotland) Act 2011, and accords with the Healthcare Principles introduced by the Act.

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

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

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

4. KEY MATTERS RELEVANT TO RECOMMENDATION

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

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

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

4.3. HSCM Complaints performance data for Quarter 3 is attached at **Appendix 1**.

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

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

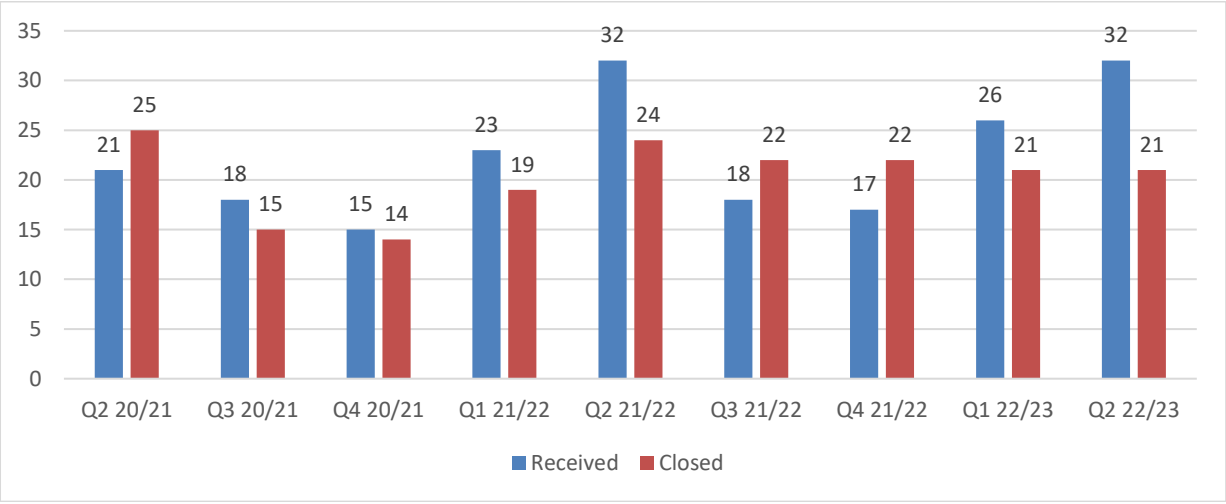
4.6. Overall, a total of 24 complaints were received during Quarter 3.

	Total Received Q1	Total Closed Q1	Total Received Q2	Total Closed Q2	**Total Received Q3**	**Total Closed Q3**
LA	9	4	7	5	**4**	**6**
NHS	17	17	25	16	**20**	**30**
	26	21	32	21	**24**	**35**

4.7. The small spike in NHS complaints received in Q2 was due to an slight increase in complaints regarding GMED service. GMED activity is increasing with 2022 being the busiest year with 92020 cases recorded. This increase in clinical demand could be a reflection of daytime practice pressures.

4.8. The clinical governance team have supported service managers to conclude the investigation of complaints and encouraged teams to prioritise complaints handling; this has resulted in a significant increase in the number of complaints closed during Q3. It should be noted that from the 30 closed (NHS) complaints 2 were closed as consent was not received and 1 was closed as it was a duplicate record.

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



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

Service	Number of Enquiries
Care at Home	3
Occupational Therapy	3
Access Team	2
Moray West	1

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. Processes for recording these appropriately are currently being defined to support effective feedback, prevent duplication and aid identification of trends and learning for all services. A segment at one of the future Clinical and Care Governance Workshops will be dedicated to complaints and enquiries handling.

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

4.13. Four comments/suggestions were received during Quarter 3 and recorded on Datix, these were all in relation to the Fiona Elcock Vaccination Centre, Elgin.

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.

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

(b) Policy and Legal

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

(c) Financial implications

None directly associated with this report.

(d) Risk Implications and Mitigation

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

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

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

(f) Property
None directly arising from this report.

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

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

(i) Directions
None directly arising from this report.

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

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

6. CONCLUSION

6.1. This report provides a summary of HSCM complaints received and closed during Quarter 3 (1 October – 31 December 2022). The governance and monitoring of complaints forms part of core business for teams and services and the provision of a good quality, effective and safe service is a key priority for all.

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

APPENDIX 1

Complaints Data (by closed complaints)

Quarter 3 (01/10/22 – 31/12/2022)

Learning from complaints

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

Table 1

Complaints Information Extracted from Datix – Actions Taken/Outcome of complaints **closed** during Quarter 3, 2022/23

	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
Action plan(s) created and instigated	1	0	0	0	1
Communication - Improvements in communication staff-staff or staff-patient	9	3	1	0	13
Education/training of staff	2	0	0	0	2
No action required	0	0	10	2	11
Risk issues identified and passed on	2	0	0	0	2
Share lessons with staff/patient/public	5	0	0	0	5
Waiting - Review of waiting times	2	0	0	0	2
Total	21	3	11	2	37*

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

Table 2

Complaints Information Extracted from Lagan:

6 complaints were **closed** during Quarter 3, 2022/23.

Directorate	Department	Service	Upheld	Partially Upheld	Not Upheld	Resolution	Grand Total
Health and Social Care Moray	Health and Social Care Moray	Access Team	0	1	0	0	1
		Care at Home	0	0	1	0	1
		Drug and Alcohol	0	0	1	0	1
		Occupational Therapy	0	1	1	0	2
		TMC Specialist Unit	0	1	0	0	1

Graph 1

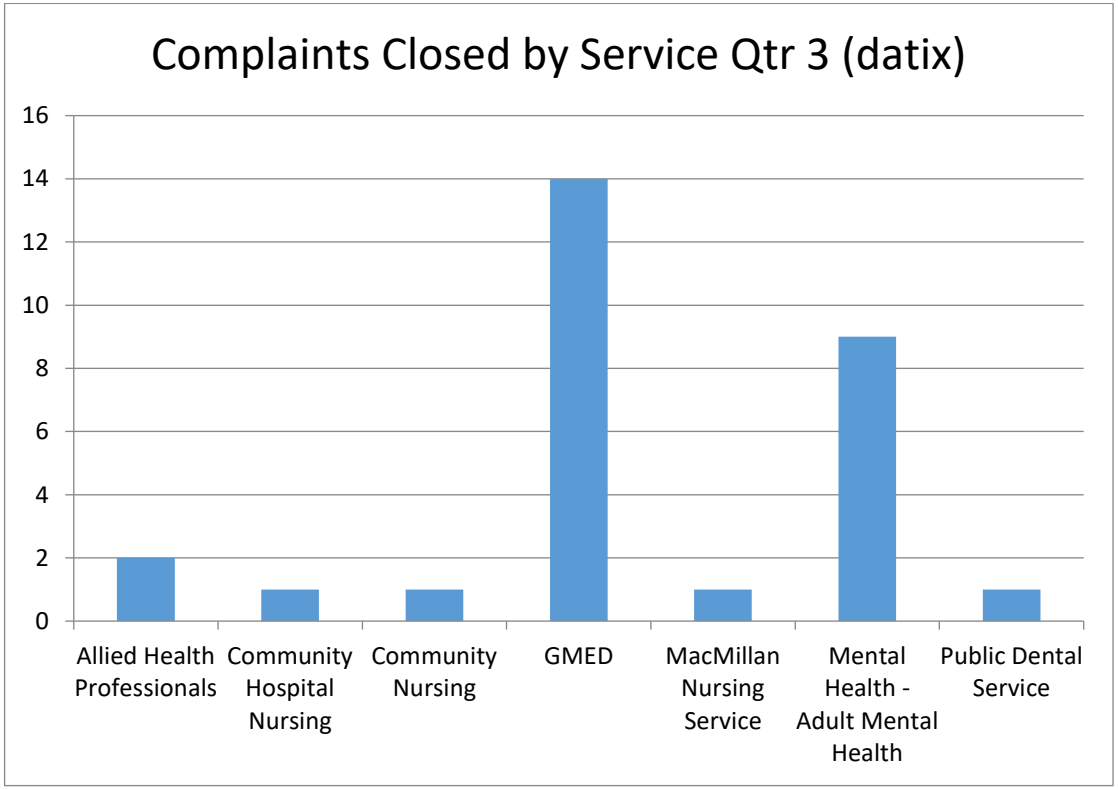


Table 3

Complaints Information Extracted from Datix – Action Taken by Service (complaints **closed** during Quarter 3, 2022/23)

	Allied Health Professionals	Community Hospital Nursing	Community Nursing	GMED	MacMillan Nursing Service	Mental Health - Adult Mental Health	Public Dental Service	Total
Action plan(s) created and instigated	0	0	0	0	0	1	0	1
Communication - Improvements in communication staff-staff or staff-patient	0	1	1	7	1	3	0	13
Education/training of staff	0	0	0	1	0	1	0	2
No action required	1	0	0	5	0	5	1	11
Risk issues identified and passed on	0	0	0	2	0	0	0	2
Share lessons with staff/patient/public	0	1	0	4	0	0	0	5
Waiting - Review of waiting times	0	0	0	2	0	0	0	2
Total	1	2	1	21	1	10	1	37*

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

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

Actions and Lessons Learned (datix)

Action Plan	Work with colleagues across Grampian with aim of standardising a Grampian wide pathway for ADHD diagnosis and treatment.
Communication	Staff reminded of the important of using official NHS Grampian publications for checking the opening hours of contractors.
	Review and improve protocol for call management
Education/Training	Telephone call handling training and support given to staff
	Staff reminded of the need for timely note keeping

Learning Outcome (lagan)

- Ensure policies and procedures are reviewed and that managers support staff to undertake particular training to improve service delivery

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

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

Table 4 – Total number of complaints **received** in Quarter 3, 2022/23

System recorded	Early Resolution / Frontline	Investigation	Not Marked	**Total**
NHS - Datix	**3** marked early resolutions	**17** marked investigation	**0**	**20**
Moray Council - Lagan	**2** marked frontline	**1** marked investigative	**1** not yet marked	**4**
Total	**5**	**18**	**1**	**24**

Table 5 – Allocation of complaints **received** in Quarter 3, 2022/23

NHS Service - Datix	
GMED	8
Community Nursing	2
AHP	3
Adult Mental Health	7
Total	**20**

Table 6 – Allocation of complaints **received** in Quarter 3, 2022/23

MC Service - Lagan	
Drug & Alcohol	1
Occupational Therapy	1
Access Team	2
Total	**4**

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 **30 Complaints closed** on the NHS system Datix during Quarter 3, 2022/23 – breakdown as follows:

Early Resolution – 3

Investigation – 26 (2 were closed as consent not received, 1 closed as duplicate record)

Ombudsman – 1

There were **6 Complaint closed** on the MC system Lagan during Quarter 3, 2022/23 – breakdown as follows:

Frontline – 3

Investigation – 3

No complaints were escalated

Table 7 – number and percentage of complaints at each stage closed within timescales **(based on complaints closed during Quarter 3, 2022/23)**

	Frontline/Early Resolution within timescale	Investigation within timescale
NHS - Datix	3 out of 3 (100%)	2 out of 23 (8.7%)
Moray Council - Lagan	0 out of 3 (0%)	2 out of 3 (66.7%)

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

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

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

Table 8 – *average time in working days to respond at stage 1, stage 2 and after escalation* **(based on complaints closed during Quarter 3, 2022/23)**

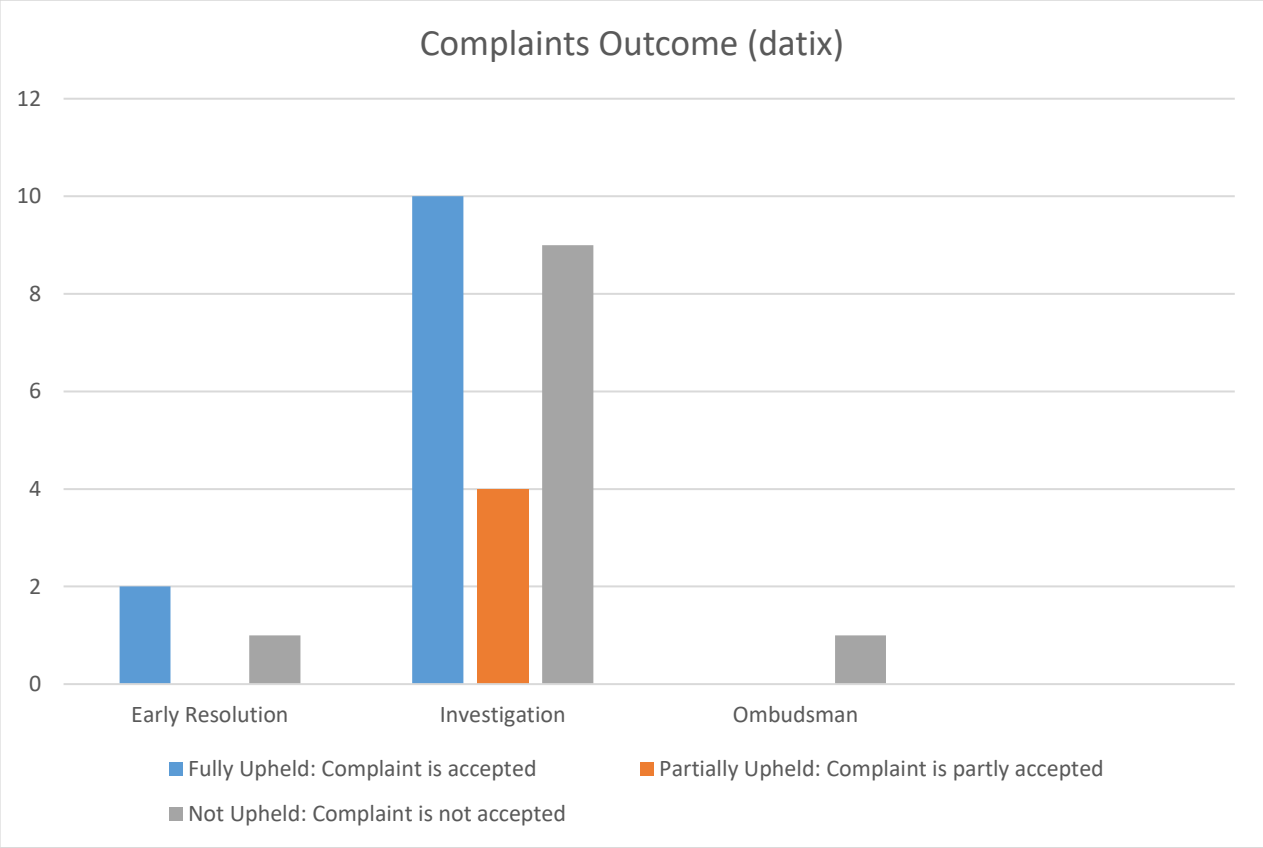
	Frontline	Investigative
NHS - Datix	1 days	44 days
Moray Council - Lagan	9 days	20 days

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 amount of complaints fully upheld, partially upheld and not upheld as recorded in Datix during Quarter 3, 2022/23. Out of 30 closed complaints on the system, 1 was a duplicate and 2 consent was not received.

From the remaining 27 complaints closed during Quarter 3 - approximately 44% were upheld, 15% were partially upheld and 41% were not upheld

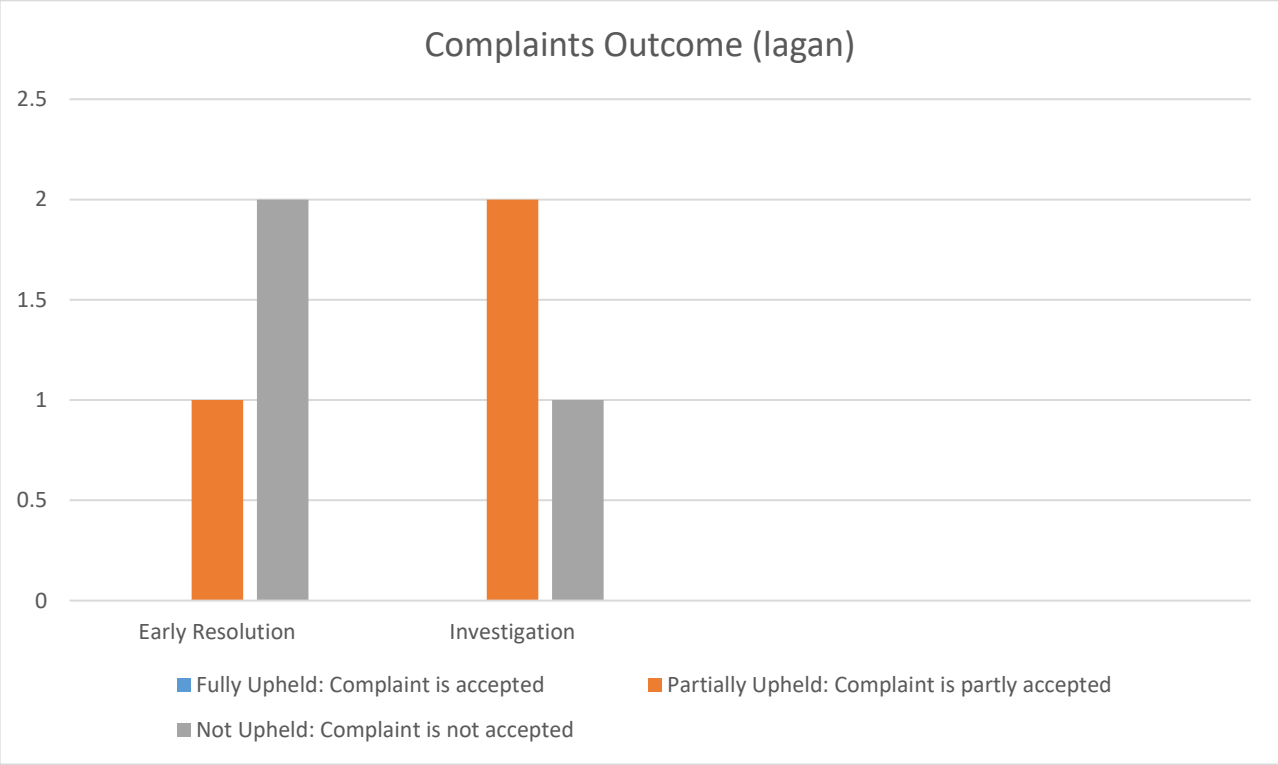


Complaints Information Extracted from Lagan:

6 complaints were **closed** during Quarter 3, 2022/23: **50% were partially upheld and 50% were not upheld.**

There were 0 Fully Upheld complaints. 0 complaints were escalated.

Graph 3 below shows the amount of complaints upheld, partially upheld and not upheld as recorded in Lagan from the **6 closed** complaints during Quarter 3, 2022/23.



REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 23 FEBRUARY 2023**

SUBJECT: **HEALTH AND SOCIAL CARE MORAY (HSCM) CLINICAL AND CARE GOVERNANCE GROUP ESCALATION REPORT FOR QUARTER 3, 2022/23**

BY: **CHIEF NURSE, MORAY**

1. REASON FOR REPORT

1.1. To inform the Clinical and Care Governance Committee of progress and exceptions reported to the Clinical and Care Governance Group during quarter 3 of 2022/23 (1 October up to 31 December 2022).

2. RECOMMENDATION

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

3. BACKGROUND

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

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

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

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

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

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

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Audit, Guidelines, Reviews and Reports

4.1 Relevant Audits, Guidelines Reviews and Reports are tabled and discussed. These include local and national information that is relevant to HSCM, for example, recommendations from Health Improvement Scotland (HIS) reports from other areas which require to be discussed and assurance given that services in Moray are aware of these and have process in place to meet/ mitigate these recommendations. Overview from Quarter 3 2022/23 is listed below:

- CRM Minutes
- HIS – Benchmarking clinical governance structure and organisation
- Service Updates:
    - GMED
    - Pharmacy
    - Moray Integrated Mental Health Services
    - Adults with Incapacity
- Adverse Events and DoC
- HSCM Risk Register
- Complaints / Feedback
- Update from Practice Governance Group

Areas of achievement / Good Practice

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

- Working with various stakeholders, including Scottish Ambulance Service (SAS), NHS24, Emergency Department (ED) and Mental Health to identify how patient pathways can be streamlined to ensure quality of patient care is improved. **GMED continues to work with stakeholders on patient pathways and professional to professional calls. Of note is a recent review of incident investigation and a concerted effort to improve communication between GMED and stakeholders to bring faster and more effective resolutions to complaints and adverse events.**
- Regular Continuing Medical Education (CME) sessions are organised for the clinical team to ensure national clinical standards and guidelines are shared and reliably implemented within GMED for a specified condition. **These are ongoing and aim to continuously ensure that patients receive evidence-based and consistent care.**
- Patient surveys to measure patient satisfaction with the quality of care provided by GMED service and clinical note audits – **Patient survey audits are pending, and a report of the outcome will be submitted when operational conditions allow.**

4.3 GMED has continued to face challenges in relation to out of hours (OOH) however the appointment of an OOH Lead Nurse (5 September 2022) has taken place and they will carry out the following functions:

- Line manager for 26 WTE Advanced Nurse Practitioner workforce
- Developing of learning, training and development programmes for ANPs and other staff
- Leading unscheduled care agenda
- Management of complaints and adverse events

4.4 The GMED service has been reviewing redirection and referral pathways out with NHS 24 pathways since August 2022. This is part of unscheduled care improvement work in response to the increased demands being experienced in Grampian and indeed across all unscheduled care services in NHS Scotland.

4.5 Up until the start of the review, multiple services in the OOH period were able to refer to GMED, which was not in line with national protocols. Such redirection pathways created an unprecedented pressure on the GMED service by allowing all professional to professional referrals to be accepted with a one hour priority, very often with no clinical indication for this. This led to lack of equity and fairness in how various patients access the service and these reviews are the improvement work by GMED to address these challenges

4.6 GMED have engaged with various stakeholders across Grampian to build up an awareness of the redirection pathways, as well as to review and update existing protocols to ensure clinical effectiveness and safe, person centred care.

4.7 To date, the GMED service have addressed pathways for care homes referrals with early indications suggesting this is working well. In July 2022, the service received 361 referrals from care homes, in contrast following improvement work, with November 2022 – 36 referrals were received

Moray Integrated Mental Health Services

4.8 The manner in which Moray Integrated Mental Health Services manages and delivers clinical governance and positive and effective complaints has been identified through benchmarking to be excellent and will be used as a “best practice” model throughout Moray.

4.9 Staffing – successful recruitment is continuing to improve staffing within the service

Pharmacy

4.10 Recruitment going well – there will be a full quota of pharmacists and technicians as set out in the original plan. This process continues to move forward successfully. The programme of training and implementation of prescribing ability for pharmacists in Moray is nearing completion and it is anticipated that this will have a positive effect on the service.

Clinical and Care Governance Developments

4.11 The schedule of workshops to reframe and drive continual improvement throughout the clinical governance framework in Moray is underway with a positive 1st workshop having been completed.

4.12 Further workshops have been scheduled to work around the framework – particularly in relation to strengthened joint working between the health and social care teams in how they monitor and communicate data around Clinical / Care / practice governance. Improvements are designed to drive fast fail cycles and to imbed preventative action and ongoing meaningful change in HSCM ways of working.

4.13 Secondary to this will be two open workshops for leaders relating to learning and understanding which underpins the theory behind the key proactive risk management process – Managing Risk Reduction Projects and reactive risk management process – Incident Investigation.

4.14 Benchmarking has been ongoing in relation to HIS, within NHSG and other trusts in terms of reviewing and adopting best practice in clinical governance.

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

4.16 Adults with Incapacity – The team have successfully mitigated key staff shortages relating to capacity assessments and are currently working to design and implement a permanent solution to deliver this service within Moray.

4.17 ADAPT – The children and families team continue to work towards improvements in relation to ADAPT. This work is ongoing and a priority for the team. The results of this work will be reported, as the improvements are implemented.

Clinical Risk Management (CRM)

4.18 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.

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

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

4.21 The Interim CG Coordinator will coordinate CG intelligence to inform the partnership of local risks relevant to patient safety, providing information to Clinical Leads, Service Managers and local governance groups and

committees. A schedule of meetings for CRM group are now resumed on a fortnightly basis following the Christmas break period.

Complaints and Feedback

4.22 HSCM complaints information for Quarter 3, 2022/23 is included in a separate report on today's agenda.

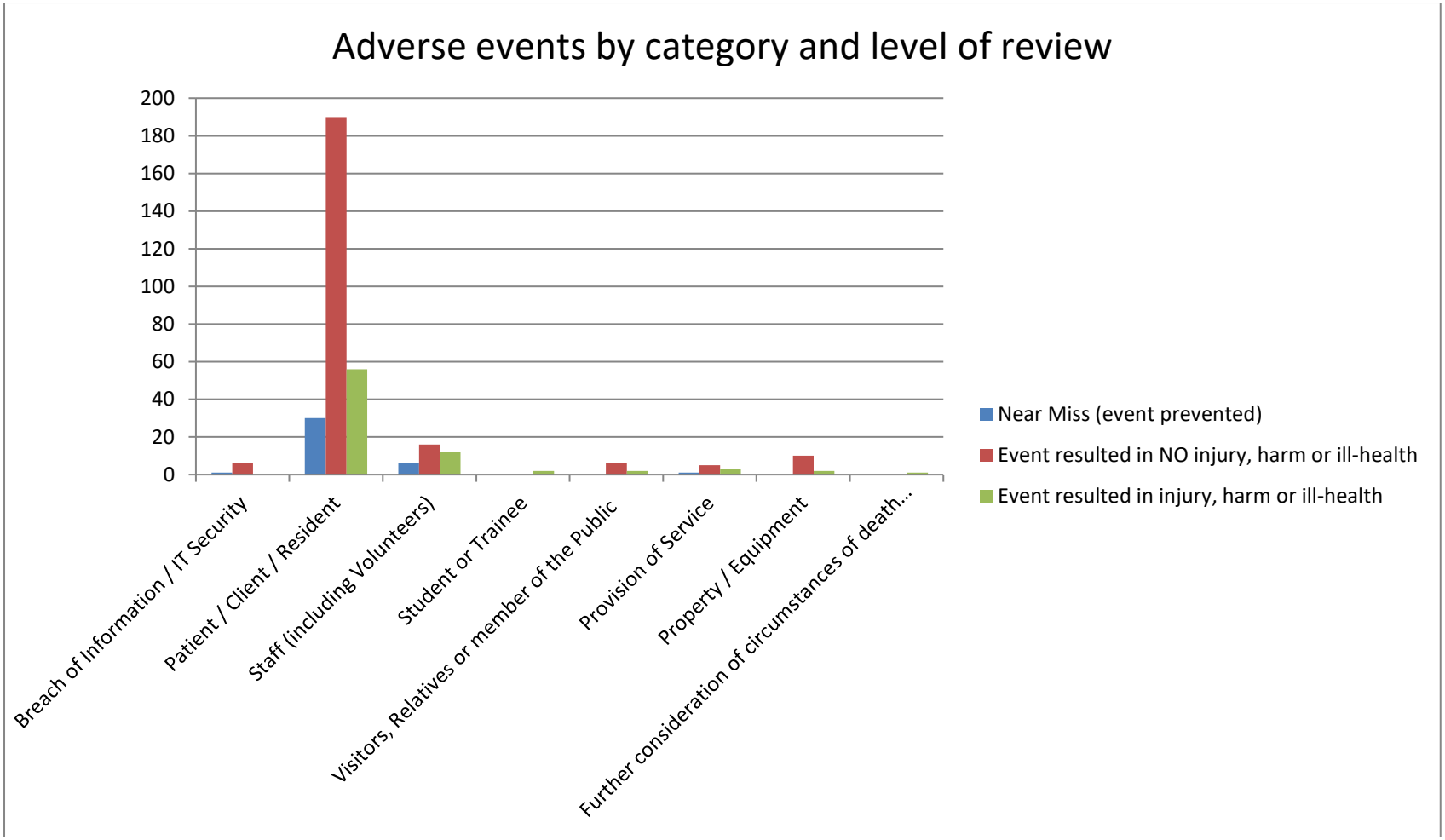
Adverse Events

4.23 Adverse Events by Category and Level of Review Reported on Datix (Quarter 3, 2022/23)

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	Total
Abusive, violent, disruptive or self-harming behaviour	82	1	83
Access, Appointment, Admission, Transfer, Discharge (Including Absconders)	23	1	24
Accident (Including Falls, Exposure to Blood/Body Fluids, Asbestos, Heat, Radiation, Needlesticks or other hazards)	129	0	129
Consent, Confidentiality or Communication	5	1	6
Diagnosis, failed or delayed	2	0	2
Financial loss	4	0	4
Fire	3	0	3
Implementation of care or ongoing monitoring/review (inc. pressure ulcers)	8	3	11
Infrastructure or resources (Staffing, Facilities, Environment, Lifts)	7	0	7
Medical device/equipment	3	0	3
Medication	28	0	28
Other - please specify in description	19	1	20
Patient Information (Records, Documents, Test Results, Scans)	2	0	2
Security (no longer contains fire)	5	0	5
Treatment, Procedure (Incl. Operations or Blood Transfusions etc.)	3	0	3
Total	323	7	330

Adverse Events

4.24 Adverse Events by Type and Result Reported on Datix (Quarter 3, 2022/23)



4.25 Adverse Events by Service and Level of Review Reported on Datix (Quarter 3, 2022/23)

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	Total
Allied Health Professionals	18	1	19
Community Hospital Nursing	87	0	87
Community Nursing	19	4	23
Community Pharmacy	1	0	1
Community Therapy Services	1	0	1
General Practice	5	0	5
GMED	14	0	14
Grampian Diabetes & Heart Failure Nurses MCN	1	0	1
Mental Health - Adult Mental Health	86	2	88
Mental Health - Learning Disabilities	1	0	1
Mental Health - Old Age Psychiatry	74	0	74
Mental Health - Specialisms	4	0	4
Primary Care	4	0	4
Public Dental Service	8	0	8
Public Health	1	0	1
Total	324	7	331

4.26 Adverse Events by Type and Severity Reported on Datix (Quarter 3, 2022/23)

	NEGLIGIBLE: Negligible/no injury or illness, negligible/no disruption to service, negligible/no financial loss	MINOR: Minor injury or illness, short term disruption to service, minor financial loss	MODERATE: Significant injury, externally reportable e.g. RIDDOR, some disruption to service, significant financial loss	EXTREME: Death or major permanent incapacity, permanent loss of service, severe financial loss	Total
Breach of Information / IT Security	7	0	0	0	7
Patient / Client / Resident	232	38	5	1	276
Staff (including Volunteers)	22	12	0	0	34
Student or Trainee	0	2	0	0	2
Visitors, Relatives or member of the Public	6	2	0	0	8
Provision of Service	6	3	0	0	9
Property / Equipment	10	2	0	0	12
Further consideration of circumstances of death required	0	1	0	0	1
Total	283	60	5	1	349

4.27 All adverse events by result by Quarter

	2020/21 Quarter 1	2021/22 Quarter 2	2021/22 Quarter 3	2021/22 Quarter 4	2022.23 Quarter 1	2022.23 Quarter 2	**2022.23 Quarter 3**
Occurrence with NO injury, harm or ill-health	193	239	271	189	218	214	283
Occurrence resulting in injury, harm or ill-health	80	61	87	79	89	98	78
Near Miss (occurrence prevented)	34	37	25	31	29	40	38
Property damage or loss	0	0	0	0	0	0	0
Death	0	0	1	0	0	0	0
Total	**307**	**337**	**383**	**299**	**336**	**352**	**349**

4.28 Adverse Events by Severity Reported on Datix by Quarter

	2020/21 Quarter 1	2021/22 Quarter 2	2021/22 Quarter 3	2021/22 Quarter 4	2022.23 Quarter 1	2022.23 Quarter 2	**2022.23 Quarter 3**
Negligible	234	281	308	231	259	264	283
Minor	66	48	72	64	70	78	60
Moderate	6	8	2	2	4	8	5
Major	1	0	0	2	1	2	0
Extreme	0	0	1	0	2	0	1
Total	**307**	**337**	**383**	**299**	**336**	**352**	**349**

All adverse events have the appropriate level of investigation implemented.

Findings and Lessons Learned from incidents and reviews:

4.29 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.

4.30 There are currently 5 Level 1 reviews in progress (at the time of reporting).

HSCM Risk Register

4.31 New risks identified on Datix are discussed at CRM. There have been 0 new risks reported during Quarter 3.

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

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

Duty of Candour

4.34 2 events were considered for Duty of Candour (DoC) during Quarter 3, these are both still under investigation.

Items for escalation to the Clinical and Care Governance Committee

4.35 Optometry patients with worsening vision problems in Moray have been adversely affected by the cessation of cataract surgery services at Dr Gray's Hospital due to ongoing theatre issues. The Optometry Team continue to examine possibilities for theatre availability for cataract surgery to be made available.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 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 Clinical and Care Governance Group members
- Sonya Duncan, Corporate Manager
- Tracey Sutherland, Committee Services Officer, Moray Council

6. CONCLUSION

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

Author of Report: Jacqui Shand, Interim Clinical Governance Co-ordinator,
HSCM Background Papers: with author

Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 23 FEBRUARY 2023**

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

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

1. REASON FOR REPORT

1.1. To update the Committee on progress against the Adult Support and Protection Multi-agency Improvement Plan, since the last update provided in October 2022.

2. RECOMMENDATION

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

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

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

iii) that a further update will be provided to the next Committee meeting

3. BACKGROUND

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

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

3.3. This plan is a multi-agency plan and is the tool used within the Moray Adult Protection Committee to provide assurance to all partners of progression and development in the work carried out.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. Following the Joint Inspection period, work has continued to ensure that all recommendations from the Joint Inspection are reflected within the Moray Multi-agency Improvement Plan. The improvement recommendations are as follows:

- The partnership should ensure the application and delivery of key processes for all adults at risk of harm is consistent and in line with the Moray Health and Social Care Partnership (HSCP) and Grampian interagency procedures.
- The partnership should ensure that full adult support and protection investigations are carried out for all adults at risk of harm who require them.
- The partnership should seek to improve the quality of chronologies, risk assessments, and protection plans. This will impact positively on the management of risk for adults at risk of harm.
- Case conferences and review case conferences should be clearly defined, involve the adult at risk of harm and unpaid carer where appropriate and should be convened for all adults at risk of harm who require them. The partnership should prioritise the full implementation of the improvement plan. Strategic leaders should ensure that the appropriate resources are made available.
- Strategic leaders should strengthen governance of adult support and protection practice. There should be robust measures in place to identify concerns early and promptly implement remedial action.
- Strategic leaders should continue to develop multi-agency self-evaluation activities. Frontline staff should be fully involved in the design, implementation and consequent improvement work.

4.2. The Improvement Plan is attached at **Appendix 1**. It has been divided into sub-sections and priority areas for improvement have been highlighted. The 7 sub sections are as follows:

- Lived Experience (Priority 1)
- Quality Assurance and Audit (Priority 2)
- ICT and recording (Priority 3)
- Policy, process and procedures
- Training and Development
- Service Design and Review
- Professional Practice

4.3. The Local Authority have invested in using Pentana audit management software. The use of this software has allowed better oversight of the improvement journey and records and tracks activities as they are progressed.

4.4. The Moray partnership recognise the benefit of working together with all partners and understands the task ahead in Moray for Adult Support and Protection and working together will only strengthen the partnership and delivery.

4.5. The Improvement and Planning sub group of the Moray Adult Protection Committee meets on a 4 weekly basis. This group is multi-agency and has been formed to discuss protection and allocation of tasks and will have full

oversight of the improvement plan and ensures all stakeholders are involved and consulted on progress and actions. This larger group will be involved in agreeing progress thus far and ensuring the improvement plan is sufficiently updated. The plan will then be presented to the Adult Protection Committee at each meet.

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

4.7. This NHSG ASP Improvement Plan is regularly reviewed by the NHSG Adult Protection Group and overseen by the NHSG Public Protection Committee. There are direct lines of communication and updates between the NHSG Adult Public Protection lead and the Moray ASP Consultant Practitioner – ensuring that both the local Moray Multi-Agency Improvement Plan and the NHSG wide plan remain synchronised.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Plan "Moray Partners in Care 2022-2032"
This report supports the Moray Strategic Plan in relation to Partners in Care, making choices and taking control over decisions affecting our care and supporting the outcome that people are safe.

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

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

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

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

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

(g) Equalities/Socio Economic Impact
Not required as there are no changes to policy as a result of this report.

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

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

(j) Consultations
ASP Planning and Improvement Sub Group.

6. CONCLUSION

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

Author of Report: Vicki Low, Moray ASP Consultant Practitioner – HSCM
Background Papers: with author
Ref:

Moray ASP Improvement Action Plan 2022-24

Report Type: Actions Report
Generated on: 08 February 2023

Background
The Improvement Action Plan was first formulated in 2019 following a series of engagement and consultation events and multi-agency workshops with the purpose of giving a clear foundation and oversight to Adult Support and Protection activities in Moray. The structure of the plan has changed over time and has been further influenced by our most recent Joint Inspection in 2022 highlighting further areas for development. The Plan is multi-agency and is the tool used within Adult Protection Committee to provide assurance to all partners of progression and development in the work that we do.

Project Work streams and objectives
The initial self-evaluation activities identified 6 main work streams, and this formed the foundation of our plan. Since the Joint Inspection, a 7th work stream has been identified. Initial Quality Assurance was intertwined within the plan – this was an area of improvement for us – and as such required its own section within the plan. We recognise the benefit of working together with all partners. We know we have a long way to do in Moray for Adult Support and Protection and working together will only strengthen our partnership and delivery of Adult Support and Protection.

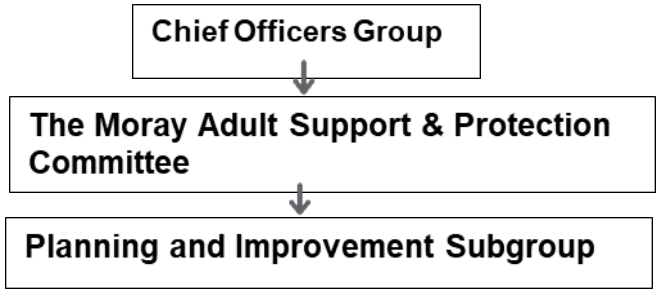
Assurance – how do we know we are achieving?
To provide all partners with the assurance they need to monitor Adult Support and Protection activity it is important that we are honest and transparent about our improvement activities and the deadlines we set. As well as the plan, we have invested in using Pentana audit management software. The plan has been relayed onto the software system and assists us in measuring outcomes and tasks completed – assisting in giving better oversight to work undertaken and clear work streams. This is new to Moray and an area we hope will provide better strategic oversight in Adult Support and Protection and assist in better efficiency and communication to all partners.

Design Principles
The plan is based on the following principles

- We will engage with our colleagues who provide ASP support in developing and then implementing the Moray Improvement Action Plan
- We will consult with our colleagues and partners in the development and then implementation of the Moray Improvement Action Plan; and monitor and review implementation, practise and outcomes to provide assurance
- We will be open and transparent with all stakeholders in terms of the improvement actions that require to be undertaken.

Governance
The following diagram illustrates the governance arrangements in relation to overseeing the project plan
The Improvement and Planning subgroup will meet on a 6 weekly basis. Our project sponsor is the Chief Social Work Officer.
The Improvement and Planning subgroup is multi-agency and representatives from Social Work, NHS, Police and Advocacy are the core members. At each, meet the Adult Support and Protection Lead officer co-ordinates the meetings. It is the responsibility for all members of the group to provide

updates prior to each meet of which will then be collated and documented onto the Plan. The updated Plan is then passed to the Chair of the Adult Protection Committee to provide assurance of work undertaken and to discuss within Adult Protection Committee.
It is further recognised that updates of the plans progress are also provided to Practice and Clinical Care Governance as update.



Priority improvement areas as identified by Care Inspectorate: -

1. The partnership should ensure the application and delivery of key processes for all adults at risk of harm is consistent and in line with the Moray Health and Social Care Partnership (HSCP) and Grampian interagency procedures.
2. The partnership should ensure that full adult support and protection investigations are carried out for all adults at risk of harm who require them.
3. The partnership should seek to improve the quality of chronologies, risk assessments, and protection plans. This will impact positively on the management of risk for adults at risk of harm.
4. Case conferences and review case conferences should be clearly defined, involve the adult at risk of harm and unpaid carer where appropriate and should be convened for all adults at risk of harm who require them. The partnership should prioritise the full implementation of the improvement plan. Strategic leaders should ensure that the appropriate resources are made available.
5. Strategic leaders should strengthen governance of adult support and protection practice. There should be robust measures in place to identify concerns early and promptly implement remedial action.

Strategic leaders should continue to develop multi-agency self-evaluation activities. Frontline staff should be fully involved in the design, implementation and consequent improvement work

Action Status	
	Cancelled
	Overdue; Neglected
	Unassigned; Check Progress
	Not Started; In Progress; Assigned
	Completed

1. Lived Experience (PRIORITY)

Code	Action Title	Agency	Due Date	Latest Status Update	Status Progress	Status Icon	Assigned To
ASP SIP Cat1.1	Review commissioned advocacy service to ensure formal advocacy services are as accessible as possible for people involved in ASP process	**AGENCY**: Local Authority **CARE INSPECTORATE PRIORITY**: 4, 5, 6	31-Mar-2023	Decision has been taken to undertake a 1-year award for Advocacy in Moray. Commissioning are finalising this.	20%		

ASP SIP Cat1.2	Listen to People - Agree and implement a systematic approach to capturing the lived experience (qualitative) of people who have been in contact with the ASP process	**AGENCY:** Local Authority **CARE INSPECTORATE PRIORITY**: 4, 6	31-Mar-2023	Conversation Cafe; booked for 04-02-2023. This will be an opportunity for individuals who have been open to ASP process to talk about their experiences and to talk about improvements to the case conference process. Verbal update to be provided by Advocacy at Feb APC. Subgroup continues to meet and explore ways of engaging with individuals who have been part of ASP process.	75%		

2. Quality Assurance and Audit (PRIORITY)

Code	Action Title	Agency	Due Date	Latest Status Update	Status Progress	Status Icon	Assigned To
ASP SIP Cat2.1	Design of ASP audit to undertake case file QA for x1 adult. This will encompass from point of referral to IASPCC findings shared with PGB and reported to APC with aim to inform practice improvement and highlight elements of good practice.	**AGENCY:** Local Authority **CARE INSPECTORATE PRIORITY**: 1, 2, 3, 4, 5, 6	28-Feb-2023	Unable to progress in January due to lack of capacity – to update for next APC	50%		Vicki Low; Sammy Robertson
ASP SIP Cat2.2	Involvement of Team Managers in undertaking Investigation documentation quality assurance exercise on a monthly basis - to evaluate practice feedback and further learning shared	**AGENCY:** Local Authority **CARE INSPECTORATE PRIORITY**: 2, 3, 4, 5, 6	30-Nov-2022	Meetings have taken place, however, these have not been attended well by Team Managers and this has resulted in a lack of progress in this area – to be highlighted on Risk Register.	0%		Vicki Low; Sammy Robertson
ASP SIP Cat2.3	Involvement of Advanced Practitioners across Adult Social Work in adult support and protection quality assurance activities for monthly single agency screening tool audits	**AGENCY:** Local Authority **CARE INSPECTORATE PRIORITY**: 3, 4, 6	31-Oct-2022	Continues to be in place	100%		Vicki Low; Sammy Robertson
ASP SIP Cat2.4	Multi-Agency IRD Summary Quality Assurance Audit to take place - review all IRDs from commencement	**MULTI AGENCYCARE INSPECTORATE PRIORITY**: 1, 2, 3, 4, 5, 6	31-Jul-2022	Next IRD audit to take place Summer 2023 Case Conference Audit activity to take place on a multi-agency basis – date to be arranged	100%		

3. ICT and Recording (PRIORITY)

Code	Action Title	Agency	Due Date	Latest Status Update	Status Progress	Status Icon	Assigned To

ASP SIP Cat3.1	All adult support and protection files to be transferred to Every Client Documents within T drive	**AGENCY:** Local Authority **CARE INSPECTORATE PRIORITY:** 1,4	31-Mar-2023	No update from ICT	10%		Samantha Morgan
ASP SIP Cat3.2	Naming convention in place for all Adult Support and Protection electronic files	**AGENCY:** Local Authority **CARE INSPECTORATE PRIORITY**: 1, 4	31-Mar-2023	Unable to progress due to lack of capacity	50%		
ASP SIP Cat3.3	Use of Pentana to measure progress of multi-agency improvement plan	**AGENCY:** Local Authority **CARE INSPECTORATE PRIORITY**: 5	31-Jan-2023	Pentana to be opened up to multi-agency colleagues Feb 2023	100%		Vicki Low; Sammy Robertson
ASP SIP Cat3.4	Information and Intelligence Subgroup to analyse data set and to improve standard of reporting to COG, APC and risk and performance management group	**AGENCY:** Local Authority **CARE INSPECTORATE PRIORITY: 5**	31-Dec-2022	Quarterly report with increased data information to be presented to APC Feb 2023 – moving forward Quarterly reports to reflect new national data set	100%		Vicki Low; Sammy Robertson
ASP SIP Cat3.5	Procedure in place for use of events/activities in relation to Adult Support and Protection activity on CF	**AGENCY:** Local Authority **CARE INSPECTORATE PRIORITY**: 1, 2, 3, 4, 5,	31-Dec-2022	Audit required of CF system on a monthly basis – to take place March 2023.	100%		Vicki Low; Sammy Robertson
ASP SIP Cat3.6	Discussion to take place regarding proposal for possible Data set from Police Scotland which would be added to the existing local date set to APC	**AGENCY:** Police CARE INSPECTORATE PRIORITY: 5	31-Mar-2023	Police can share information regarding ASP referrals and Concerns – to further discuss **Assigned to:** Vicki Low, Bruce Buntain	0%		

4. Policy, Process and Procedures

Code	Action Title	Agency	Due Date	Latest Status Update	Status Progress	Status Icon	Assigned To
ASP SIP Cat4.1	TM oversight and involvement of chairing of all RASPCC, in line with the Op Guidance, to support clearly defined ASPCC and RASPCC process - This will include regular updates and review to ensure collaboration to be discussed within the ASP Op meet	**AGENCY**: Local Authority CARE INSPECTORATE PRIORITY: 1, 2, 3, 4, 5	30-Nov-2022	Update Feb 2023 – lack of attendance at TM meetings – to discuss review meetings. This has been further impacted by lack of admin capacity – to be included in Risk Register	0%		Tracy Stephen

ASP SIP Cat4.2	Core Group of front line practitioners formed to review Investigation documentation on CF - specific attention to the management of risk and protection planning within recordings	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITY: 1, 3, 6	30-Nov-2022	Update Feb 2023 – practitioners met to discuss January 2023 – work on going and review activities will be set moving forward	100%		Sammy Robertson
ASP SIP Cat4.3	Core Group of front line practitioners formed to review Screening Tool documentation on CareFirst - specific attention to the management of risk, protection planning and application of the 3-point test	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITY: 1, 3, 6	30-Nov-2022	Update Feb 2023 – core group of practitioners met January 2023 – in progress – review activities will be set moving forward	100%		Sammy Robertson
ASP SIP Cat4.4	Core Group of front line practitioners formed to devise, design and implement Large Scale Investigation recording and investigation documentation on Carefirst. Attention required in relation to risk management and protection planning	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITY: 1, 3, 6	30-Nov-2022	Subgroups to commence August 2022. Due to LSI activity this activity has been completed by LSI lead Officers and will be reviewed alongside x8 council officers following current LSI to inform any changes to document Feedback meeting with practitioners took place and further small changes agreed as well as practitioner guidance produced and to use document moving forward with further review following each LSI activity undertaken **Assigned to:** Vicki Low	100%		Vicki Low; Sammy Robertson
ASP SIP Cat4.5	Full Review of the Decision Specific Capacity Tool to be undertaken on a multi-agency basis – with input from NHSG and Lead Agency council employed staff.	**AGENCY:** NHS Grampian CARE INSPECTORATE PRIORITY: 1, 2, 5, 6,	31-Jan-2023	30-01-2023: Tool revised updated and completed. Distributed out to all agencies along with a briefing note to support roll out. To be discussed in Council Officer meetings + main Grampian Psychiatrist clinical meetings. **Assigned to:** Kenny O 'Brien	100%		
ASP SIP Cat4.6	Initiate ASP Champions Role within NHSG - ensure that staff have local contacts and links for advice and support - alongside more formal structures	**AGENCY:** NHS Grampian CARE INSPECTORATE PRIORITY: 1, 5, 6	28-Feb-2023	30-01-2023: Delayed due to NHS clinical pressures. However, nominations from teams/areas expected in February. Plans already in place to train Champions + offer additional support. Now aiming for end of February 2023 launch. **Assigned to**: Kenny O 'Brien	75%		
ASP SIP Cat4.7	iVPD local process review to take place in order to identify opportunities for	**AGENCY:** Police CARE	31-Dec-2022	Activity well underway with multi-agency sub group formed and active discussion and planning	50%		

	improvements in quality of information shared, and expectations of agencies receiving Adult Concern Reports from Police	INSPECTORATE PRIORITY: 1, 3, 5		taking place **Assigned to**: Sheila McDermott			
ASP SIP Cat4.8	Ensure local and Grampian processes align and embed. This will be monitored via QA activities and regular briefing sessions. Work to be undertaken on a Grampian-wide basis to align the Grampian Procedures with the revised COPs and Local Guidance.	**Agency:** Multi-Agency CARE INSPECTORATE PRIORITY: 1, 2, 3, 4, 5, 6	31-Jan-2023	Subgroup currently updating Grampian procedures to reflect revised codes of practice. QA activities on going - to continue to develop good communications and continually review effectiveness - end date to be extended to March 2023, likely to go through governance groups April/May 2023	80%		

5. Training and Development

Code	Action Title	Agency	Due Date	Latest Status Update	Status Progress	Status Icon	Assigned To
ASP SIP Cat5.1	Clear training calendar available for external partners to book via Eventbrite	**AGENCY**: Local Authority CARE INSPECTORATE PRIORITY: 1, 3	31-Dec-2022	Update Feb 2023 – training facilitator current on sick leave	50%		
ASP SIP Cat5.2	Collaboration with Social Work training to facilitate complex risk assessment across adult social work	**AGENCY**: Local Authority CARE INSPECTORATE PRIORITY: 1, 2, 3	31-Dec-2022	Update November 2022 – Complex risk assessment for single agency devised and cascaded and presented across adult social work. Continue to discuss pan Grampian for multi-professionals – to change to multi-agency action for pan Grampian approach as of November 2022. Leads – Vicki Low **Assigned to**: Vicki Low, Social Work Training	100%		
ASP SIP Cat5.3	Adult Support and Protection Training Plan to be available to all practitioners throughout Adult Social Work, Social Care and 3rd sector	**AGENCY**: Local Authority CARE INSPECTORATE PRIORITY: 1, 2, 3, 4	31-Aug-2022	Training Plan disseminated to all 3rd sector - March 2022. Training Plan available on Moray Protects webpage - April 2022. Training Plan available to all Social Work Teams - April 2022. Training Plan available to all housing and children services - July 2022. **Assigned to**: Vicki Low	100%		Vicki Low; Sammy Robertson
ASP SIP Cat5.4	Collaboration to take place with Child Protection to design and deliver Chronology training across Children and Adult Social	**AGENCY:** Local Authority CARE INSPECTORATE	31-Dec-2023	Update Feb 2023 – National Chronology Implementation Group meeting (2 meets so far) Terms of Reference in place for the Groups.	40%		Vicki Low; Sammy Robertson

	Work	PRIORITY: 1, 3,		Attached for Feb 2023 discussion. Local Chronology Implementation Group to meet in due course to look at local approach Children and Adult Services.			
ASP SIP Cat5.5	Clear and up to date records of all Adult Support and Protection training undertaken - Module, 1, 2, 3 and 4 - including when Council Officer refresher training is required	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITY: 1, 5, 6	31-Aug-2024	Update- Feb 2023 – no update Training facilitator on sick leave	10%		
ASP SIP Cat5.6	Council Officer Handbook detailing tasks in relation to Adult Support and Protection duties and role	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITY: 1, 2, 3, 4	31-Jul-2023	February 2023 – delayed to amend end date – this is due to delivery of Grampian wide training in risk assessments and chronologies – guide to reflect these changes.	50%		Vicki Low; Sammy Robertson
ASP SIP Cat5.7	Develop Practitioner Guidance on Self-neglect and Hoarding	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITY: 1, 2, 3, 4,	30-Nov-2022	Delayed due to Training Facilitator sick leave	75%		
ASP SIP Cat5.10	New training framework for ASP to be embedded with all patient facing staff receiving a facilitated level 2 ASP training course	**AGENCY:** NHS Grampian CARE INSPECTORATE PRIORITY: 1, 2, 3, 4, 5	31-Aug-2024	Training framework signed off and in place. ASP Level 2 now mandatory for NHSG patient facing staff with a 3-year repeat built in. Courses being run. **Assigned to**: Kenny O'Brien	100%		
ASP SIP Cat5.11	For NHSG staff recording of ASP input and activity - revise ASP Level 2 Training to include specific section on Health records and ASP, good practice examples to be included.	**AGENCY:** NHS Grampian CARE INSPECTORATE PRIORITY: 1, 2, 3, 4, 5,	31-Mar-2023	Training curriculum now revised and being delivered. Practice note completed and signed off/endorsed by the Clinical Professional Directors Forum for additional weight. Note distributed to all staff. **Assigned to**: Kenny O'Brien	100%		
ASP SIP Cat5.12	Financial Harm subgroup lead by Police Scotland (John Webster)	**AGENCY:** Police CARE INSPECTORATE PRIORITY: 1, 5, 6,	31-Aug-2024	Subgroup refreshed, new Terms of Reference compiled and Financial Harm Group firmly established. They are accountable to the Grampian ASP Working Group. **Assigned to**: John Webster	100%		
ASP SIP Cat5.13	Mandatory online training for ASP rolled out and to be undertaken by all officers.	**Agency**: Police CARE INSPECTORATE	30-Nov-2022	Compliance rate requested - this can then be reviewed on a regular basis.	90%		

		PRIORITY: 1, 2, 3, 4, 5, 6		**Assigned to**: Bruce Buntain			
ASP SIP Cat5.14	Training and briefings to existing and new members (on induction) in relation to their roles and responsibilities on the ASP committee	**MULTI AGENCY** CARE INSPECTORATE PRIORITY 5, 6,	31-Aug-2024	Training and updates delivered as required **Assigned to**: Samara Shah	100%		
ASP SIP Cat5.15	Implement learning points from Multi-Agency IRD Audit	**MULTI AGENCY** CARE INSPECTORATE PRIORITY: 5, 6,	31-Oct-2022	IRD Report written and presented to APC Sep 2022. Presented to Council Officer Forum and Practice Governance. Further reflection and implementation of learning point to be taken forward at next council officer session – as well as specific discussion with IRD chairs – scheduled throughout Sept and Oct **Assigned to**: Vicki Low and Elaine MacDonald for Social Work	100%		

6. Service Redesign and Review

Code	Action Title	Agency	Due Date	Latest Status Update	Status Progress	Status Icon	Assigned To
ASP SIP Cat6.1	Adult Social Work consultation - design and implementation of a service wide development and improvement plan to reflect on ASP inspection, SDS standards and national and local policy	**AGENCY**: Local Authority CARE INSPECTORATE PRIORITY: 5, 6,	31-Oct-2022	Initial discussions have taken place with Team Managers with regard to importance of improvement and development for Social Work. Consultation Workshops planned for end Sep 2022. **Assigned to**: Vicki Low	100%		~~Jane Mackie~~; Tracy Stephen
ASP SIP Cat6.2	To develop a multi-agency approach and training for 2nd persons in Adult support and protection	**MULTI AGENCY** CARE INSPECTORATE PRIORITY: 1,2, 3, 4, 5	31-Dec-2023	Progress – local 2nd Person training being undertaken in Moray – however, not Multi-agency to have further discussion regarding multi-agency contribution within Grampian Learning and Development Group	0%		
ASP SIP Cat6.3	ASP Live Event	**MULTI AGENCY** CARE INSPECTORATE PRIORITY: 5, 6	31-Jul-2023	Postponed to 2023 – amendment to end date due to operational Priorities. Theme – Grampian Procedures. **Assigned to**: Vicki Low, John Lumsden. Kenny O'Brien, Anne Pendery	10%		

ASP SIP Cat6.4	Discussion to take place within COG and APC regarding capacity and gaps in service to ensure clear oversight of matters by our more senior leaders	**MULTI AGENCY** CARE INSPECTORATE PRIORITY: 5. 6	31-Oct-2022	Discussions taking place at both COG and APC regarding gaps and capacity issues. This is also reflected within our APC Risk Register and is a standing item agenda	100%		

7. Professional Practice

Code	Action Title	Agency	Due Date	Latest Status Update	Status Progress	Status Icon	Assigned To
ASP SIP Cat7.1	Regular Council Officer Forums – to include regular feedback sessions	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITY: 1, 2, 3, 4, 5, 6	30-Nov-2022	Council Officer Forums in place. Formally recorded and training materials to be available within SharePoint for CO viewing - TO be reviewed Nov-22 by consultation with CO's Council Officer Forum due in December **Assigned to**: Elaine MacDonald, Suzy Gentle	100%		
ASP SIP Cat7.2	Regular Team Manager 'catch up' meetings to take place to discuss adult support and protection practice within teams	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITY: 5, 6	30-Nov-2022	Update- due to lack of capacity – it has been difficult to progress this, however, locally we do have our Operational Group in which sharing of good practice does take place.	50%		Vicki Low; Sammy Robertson
ASP SIP Cat7.4	Review across all patient facing areas that professional supervision is offered/available	**AGENCY:** NHS Grampian CARE INSPECTORATE PRIORITY 5, 6,	30-Sep-2022	Scoping complete + managers/staff now have ASP as a regular item on 1:1's and supervision discussions. Also a regular item now on team meeting agendas. NHSG Public Protection Supervision arrangements now finalised, consulted on, and approved. The professional supervision document is now live. **Assigned to**: NHSG ASP	100%		

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 23 FEBRUARY 2023**

SUBJECT: **HEALTH AND SOCIAL CARE MORAY CLINICAL AND CARE GOVERNANCE UPDATE**

BY: **CHIEF NURSE - MORAY**

1. REASON FOR REPORT

1.1. To inform the Clinical and Care Governance Committee of the outcome of the first Clinical and Care Governance workshop to refresh the structure of Clinical and Care Governance within Health and Social Care Moray.

2. RECOMMENDATION

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

i) the content of this report and the associated outcomes and recommendations therein; and

ii) that an update will be provided at the next meeting.

3. BACKGROUND

3.1. In response to the guidance of the Scottish Government Clinical and Care Governance Framework for Integrated Health and Social Care Services in Scotland a review has been ongoing relating to the Health and Social Care Moray clinical and care governance structures against this framework. A previous workshop was held in January 2020.

3.2. Committee members were informed in February 2022 of a proposed follow up planned for April / May 2022. This did not occur on the proposed timescale due to staff changes throughout the clinical and care governance team. A report to Committee on 27 October 2022 provided an overview of the developments in relation to clinical and care governance to date and set out the intention to hold the first in a series of workshops in January 2023.

3.3. The workshops have been planned and designed specifically to accelerate this task and ensure that robust clinical governance structures within the Partnership are implemented over the coming months of 2023.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The key outcomes of the Workshop 1 held on 19 January 2023 are presented for consideration:

4.2. There were a relatively low number of attendees, however those in attendance made significant headway and returned overall positive feedback and as a result, attendance numbers are expected to build throughout the workshop series.

4.3. There was overall agreement that closer working between departments, increased transparency and more shared working practices and systems were a key objective as we move forward.

4.4. Current blocks to effective working were discussed and challenges explored with resolutions being created within the workshop.

4.5. Senior Leadership worked through current processes outlining areas where more robust processes, communication systems and staff support were required and beginning the process of outlining what this will look like.

4.6. Staff ended the workshop feeling enabled and inspired with the belief that the proposed improvements would make significant positive changes to their areas of responsibility.

4.7. The next workshop aims to re-draft the communication on Clinical and Care Governance with a view to integrating disciplines more closely and to communicate risk and improvements more rapidly and effectively. This piece of work is scheduled to be completed by end of February 2023 and the outcomes will be communicated to the Committee at the next scheduled meeting.

4.8. Updates to governance for services and systems which must be incorporated – namely Children & Families, Justice social work, were discussed with the next workshop being planned in February 2023 in order to work specifically on the integration.

4.9. The impact of the National Care Services Bill and the required changes will need to be incorporated under the auspices of this Bill. This is at the forefront of consideration as we proceed forward through the workshop series.

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"

Governance arrangements are integral for the assurance of the delivery of safe and effective services that underpins the implementation of the strategic plan.

(b) Policy and Legal
Compliance with Scottish Government National Framework for Clinical and Care governance outlining the statutory duties under The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014

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

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

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

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

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

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

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

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

6. CONCLUSION

6.1 The committee are asked to acknowledge the challenges imposed on the refreshing and updating of the clinical and care governance framework created by the Covid pandemic, including the redeployment of key personnel to frontline services. As noted a number of key stakeholders have changed posts and further engagement is required by new staff to move the agenda forward. This work will be incorporated into further workshops.

6.2 The first workshop has been undertaken within the defined time frame. The feedback has been positive, citing an increased positive outlook and sense of empowerment of those involved.

Author of Report: Jacqui Shand, Interim Clinical Governance Coordinator (HSCM)
Background Papers:
Ref: