Clinical and Care Governance Committee

Thursday, 25 May 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, 25 May 2023** at **14:00** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

SEDERUNT

Mr Derick Murray (Chair)

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

Mr Ivan Augustus (Non-Voting Member)
Ms Karen Donaldson (Non-Voting Member)
Mrs Val Thatcher (Non-Voting Member)
Dr Robert Lockhart (Non-Voting Member)
Ms Elizabeth Robinson (Non-Voting Member)
Dr Malcolm Simmons (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, 23 February 2023

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 Fiona Robertson, Ms Tracy Stephen

APOLOGIES

Mr Ivan Augustus, Professor Duff Bruce, Mr Sean Coady, Ms Karen Donaldson, Ms Jane Ewen, Mr Graham Hilditch, Dr Robert Lockhart, Ms Deborah O'Shea, Mrs Val Thatcher

IN ATTENDANCE

Also in attendance at the above meeting were Mrs Sheila Brumby and Mrs Tracey Sutherland, Committee Services Officer.

1. Chair

The meeting was chaired by Mr Derick Murray.

2. Declaration of Member's Interests

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

3. Minutes of meeting of 27 October 2022

The minute of the meeting of 27 October 2022 was submitted and approved.

4. Action Log - 27 October 2022

The Action Log of the meeting for 27 October 2022 was discussed and updated.

5. 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 January 2023.

Following consideration the Committee agreed 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.

6. Complaints Quarter 3 2022-2023

A report by the Chief Nurse, Moray informed the Committee of complaints reported and closed during Quarter 3 (1 October 2022 – 31 December 2022).

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

7. Clinical and Care Governance Group - Q3 Escalation Report

A report by the Chief Nurse, Moray informed the 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).

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

8. Adult Support and Protection Multi Agency Improvement Plan

A report by the Head of Service/Chief Social Work Officer updated the Committee on progress against the Adult Support and Protection Multi-agency Improvement Plan, since the last update provided in October 2022.

Following consideration the Committee agreed to note:

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

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

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

9. Clinical and Care Governance Update Report

A report by the Chief Nurse, Moray informed 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.

Following consideration the Committee agreed to note:

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.

10. Items for Escalation to MIJB

There were no issues escalated to the Moray Integration Joint Board.

MEETING OF MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE

THURSDAY 23 FEBRUARY 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 Cllr Scott Lawrence	February 2023	Chief Nurse	Completed February 2023

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 25 MAY 2023**

SUBJECT: **STRATEGIC RISK REGISTER – MAY 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 May 2023.

2. RECOMMENDATION

2.1 It is recommended that the Clinical and Care Governance Committee consider and note the Strategic Risk Register included in APPENDIX 1.

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. Any changes made to the risk register since it was last presented to the MIJB are highlighted using red text.

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 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 slowly. Covid-19 remains a challenge operationally, with additional infection control measures and staff absences.

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 continue to be covered as part of a Clinical Governance workstream in workshops which commenced January 2023. These are now more team and service focused and delivered locally.

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 (para 12 of the minute refers). 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 (para 13 of the minute refers).

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 HSCM.

4.9 The possibility of planned power outages continues to be a focus for Civil Contingency groups and Business Continuity Planning continues. Additional support has also been provided by HSCM to assist Primary Care Contractors with their 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 (para 7 of the minute refers) and the 2022-23 final unaudited accounts are due to MIJB on 30 June 2023. The 2022-23 outturn is not yet finalised but will be part of the financial update to MIJB on 30 June 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. 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 "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 MAY 2023

RISK SUMMARY

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

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

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

1		
Description of Risk: *Regulatory*	The Integration Joint Board (IJB) does not function as set out within the Integration Scheme, Strategic Plan and Scheme of Administration and fails to deliver its objectives or expected outcomes.	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**MEDIUM**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	The strategic plan "Partners in Care 2019-2029" was revised and presented as "Partners in Care 2022 to 2032", this was approved by MIJB in November 2022. Membership of IJB committees 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" 2022-32 will be presented Spring 2023.	
Rationale for Risk Appetite:	The Board, staff and providers across Moray are all committed to ensuring high standards of clinical care & governance through operational policies. Innovation and new ways of working may mean traditional regulations do not exist, or are contradictory. We will only take regulatory risks knowingly, following consultation with the relevant regulatory body and where we have clear risk mitigation in place.	
Controls:	• Integration Scheme. • Strategic Plan "Partners in Care" 2022-32 • Governance arrangements formally documented and approved by MIJB January 2021. • Agreed risk appetite statement. • Performance reporting mechanisms. • Consultation with legal representative for all reports to committees and attendance at committee for key reports. • Standing orders have been reissued to all members	
Mitigating Actions:	Induction sessions 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:	The new strategic delivery plan and will incorporate the work being taken forward for Self-Directed support, Hospital at Home and Locality Planning.
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	**INCREASING**
Rationale for Risk Rating:	The 2021/22 and 2022/23 settlement saw additional investment for health and social care that was passed through to the MIJB and in 2023/24 saw funding for recurring commitments. ~~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 impact of which will be to reduce the level of ear marked reserves in the MIJB. The Revenue Budget 2023/24 was approved by MIJB on 30 March 2023 as a balanced budget. A ~~small~~ significant ambitious savings plan of £4.1 million was approved ~~and achieved~~. Additional Scottish Government ~~investment~~ funding was provided again for 2023/24, this is to meet additional recurring policy commitments in respect of adult social care pay uplift for externally provided services and free personal and nursing care rates ~~seeks to ensure that capacity can be maximised and ensuring system flow~~. The update medium Term Financial Framework was presented as part of the budget papers on the 30th March 2023 ~~however, it is imperative that~~ this will be ~~is~~ further reviewed during the 2023/24 year to ensure alignment with the ~~upcoming revisions~~ recently reviewed ~~to the~~ Strategic Plan and for the delegation of Childrens Services and Criminal Justice is planned to be presented to MIJB by 30 September 2023 ~~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 Covid-19 recovery and transform stage ~~phase~~ there has been no additional 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~~ were ~~presented to~~ approved by the Board ~~for approval~~ as part of the budget setting procedures for 2023/24. This ~~should~~ will be a focus of continuous review to ensure any investment is made taking cognisance of existing budget pressures. A revised Financial Framework was presented to the MIJB on 30 March 2023, and a further review will take place by 30 September 2023. The Senior Management Team will continue to ~~met in February 2023 to~~ consider and plan for the financial challenges for 2024/25 and beyond.
Mitigating Actions:	Risk remains of the challenge that the MIJB can deliver transformation and efficiencies at the pace required whilst dealing with the emerging financial pressures ~~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~~ 1,297,158 as at December 2023 was reported to the IJB on 30 March 2023.at 30 Sept 2022. .
Comments:	Senior managers continue to work with Chief Officer and Chief Financial Officer to address the continuing financial challenge, continuing to seek efficiencies and opportunities for real transformation as we look to make efficient and effective investment in services that are truly transformational. There are additional pressures from the cost of living crisis, increasing energy bills, inflation and staff pay awards ~~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	**NO CHANGE**
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 continues to review the large number of fixed term and seconded posts. This will continue as temporary contracts conclude. It is hoped that this will improve some of the instability teams felt during the pandemic response. This will also allow consideration of post redesign, service needs and potential financial savings. This will continue to be reviewed by the Senior Management Team. Care Homes in Moray continue to face difficulties with recruitment and retention of staff. Efforts are being made to provide support but the situation remains challenging. The transition from EU membership has not presented any specific concerns for workforce and this will continue to be monitored. The impact of 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. The lack of suitable housing for Health and Social Care staff has resulted in people not being able to take up posts in Moray.	
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. There will be a 2 day event 16/17 May 2023 for the Senior Management Team as part of a Grampian wide event. Communications & Engagement Strategy was approved in November 2019 and continues. Council and NHS performance systems in operation with HSCM reporting being further developed and information relating to vacancies, turnover and staff absences is integral to this. Managers are highlighting any areas of concern and where appropriate this is identified in operational risk registers. 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. Moray Council are carrying out a study of accommodation needs, including people working in the Health and Care sector.
Mitigating Actions:	System re-design and transformation. Organisational Development Plan and Workforce plan were updated and approved by MIJB in November 2019. The updated Workforce plan has been submitted to Scottish Government and comments were received by the HSCP in October 2022. These are currently being worked through. 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 has commenced on the plans for iMatter 2023/24. 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. The unaudited accounts and governance statement for 2022/23 will be presented to MIJB June 2023 and then the audited accounts will return to committee in September 2023 for agreement. 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. The SMT are currently considering how any proposed service changes consider the PSED as part of the consultation process. 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. A Public Engagement and Communications Officer is currently being recruited to. 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 2022/23 were audited and approved in March 2023 and are now published. 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:	As a result of the Covid 19 response, progress was made in a number of areas. SMOC information is updated, control room guidance updated and expanded, control centre protocols were implemented and remain in place and management teams have responded in an agile, responsive and collaborative way under very challenging conditions. Teams continue to do their best but there are areas where they still feeling overwhelmed and service delivery is challenging. With effect from March 2021 MIJB is defined as a Category 1 responder under the Civil Contingencies (Scotland) Act and there are additional requirements for preparedness that is being taken forward in partnership with NHSG and Moray Council emergency planners.	
Rationale for Risk Appetite:	The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act and the Category 1 status applied in March 2021, and work with partner organisations to meet these obligations.	
Controls:	Winter Preparedness 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 System 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 are now updated for most services and this review continues across HSCM. Knowledge of critical functions and ability to respond quickly and effectively has been in evidence during incidents such as Gas outages in Keith (January and February 2021) and Covid response, Storms (Arwen, Malik and Corrie) – debriefs carried out and learning identified. A Resilience Newsletter 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. Additional sessions delivered to Primary Care Contractors to assist with their Business Continuity Planning around power outages. Regular system wide meetings to discuss potential Industrial Action implications and service planning.	

	A review of the Festive season arrangements was completed and as a result all services are now required to provide information about service cover available over holiday long weekends which enables a more collaborative and supportive approach.
Mitigating Actions:	Information from the updated BIA/BCP informed elements of the Winter Preparedness Plan A Friday huddle continues, this allows the status of services across the whole system to provide information and contact details to the Senior Manager on Call (SMOC) over the weekend. If any potential issues are highlighted the relevant Persons at Risk Data is compiled and if appropriate, shared with relevant personnel. NHSG have introduced system wide daily huddles to manage the flow and allocation of resources which require attendance from Dr Grays and HSCM. 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

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

	experience. This presents a potential organisational risk in terms of compliance, and our ability to provide assurance on discharging our civil contingency arrangements. This has been highlighted to the Chief Officer and IJB. The debriefs from the storms in 2021/22 have identified lessons learnt for Grampian Local Resilience Partnership and more locally for the response co-ordination within Moray. 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. The 'Care for People' strategic document has been presented to HSCM SMT and CMT for comment it will then be presented to MIJB. It is anticipated this will be completed by end April 2023. A draft operational response plan has been drawn up and will also be presented for approval shortly after. An information session including the 'Care for People' element was delivered on 2 May 2023, to senior managers who carry out the role of SMoC, this includes input from Moray Council Emergency Planning Officer and NHS Grampian. 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 Business Continuity plans for February 2023. Development of a HSCM Persons at Risk Database continues and all partners are now involved looking to improve the quality of the data held.
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. A further session will take place in Moray in May 2023. Many services have business continuity arrangements and some are overdue for an update. Work has progressed in identification of a critical functions list for agreement by System Leadership Group that will inform planning arrangements going forward. There will need to be changes made to business continuity plans following the implementation of additional ICT resources in services which have provided a greater deal of resilience for some services and functions – albeit reliant on electricity supply. A schedule of review and exercising of business impact

	assessments and plans has been scheduled for this year across services. All services have been requested to prioritise their Business Continuity planning with a particular lens on power outages. Annual report on progress against NHS resilience standards was presented to the APR committee on 30 March 2023. Report on the implications of the designation as a Category 1 responder was presented to MIJB 25 November 2021. Work is currently underway to plan for possible National Power Outages across the UK. This is being co-ordinated across Grampian to ensure all Partners are involved. Information/planning sessions were also delivered via HSCM to our Primary Care partners. They were invited to share any emergency plans with the partnership.
Comments:	The requirements of a Category 1 Responder continue to increase in demand placing increased pressures across already overstretched services and managers. 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	**NO CHANGE**
Rationale for Risk Rating:	Considered medium risk due to the impact of Covid-19 and resultant efforts required to remobilise services and/or the increase in workloads stretching a workforce that has been under sustained pressure for a considerable time. The ongoing impact of the Covid 19 pandemic 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. Workshops took place in January and February 2023, 'A conversation about Clinical Governance'. Additional operational workshops will continue in 2023. Complaints and compliments procedures in place and monitored. Clinical incidents and risks are being reviewed on a fortnightly basis to ensure processes are followed appropriately and consistently and responses are recorded in a timely manner. Adverse events and duty of candour procedures in place and being actioned where appropriate and summary reports submitted to CCG committee.	

	Reports from external inspections reported to appropriate operational groups and by exception to SMT for subsequent reporting to CCG or Audit Performance and Risk Committee as appropriate, albeit there was a reduction in some areas of external inspection reporting during the Covid period due to social distancing restrictions. It is anticipated that these will begin to increase over the coming year. 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.
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. The findings of these events were compiled and outcomes are assessed by the relevant service leads and SMT. A further round of audits on Social Care will now be completed and a full report will be considered if necessary, dependant on outcomes. 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 was approved and development of delivery plan is underway. Performance is regularly reported to MIJB. Revised Scorecard being developed to align to the new strategic priorities. Best practice elements from each body brought together to mitigate risks to MIJB’s objectives and outcomes. Chief Officer and SMT managing workload pressures as part of budget process. A daily Huddle and write up circulates the picture on performance across community and acute services for the Portfolio and service managers have a shared understanding of the pressures in the system and mitigations taking	

	place. Work continues on refinement of G-OPES (Grampian Operating Pressures and Escalation System) led by NHSG but being developed locally to identify the triggers and resultant actions required in services to respond to pressure points.
Mitigating Actions:	Service managers monitor performance regularly with their teams and escalate any issues to the System Leadership Group (SLG) for further discussion to provide wider support, developing shared ownership and a greater understanding across the whole system. Key operational performance data is collated and circulated daily to all managers. A Daily dashboard is held on illuminate for managers to access to ensure any potential issues are identified quickly so action can be taken. This dashboard is being reviewed and will be further developed with the intention of further dashboards to provide a whole system overview. This has been discussed at SLG and agreed. Performance information is presented to the Performance sub group of Practice Governance Group to inform Social Care managers of the trends in service demands so that resources can be allocated appropriately.
Assurances:	Audit, Performance and Risk Committee oversight. Operationally managed by service managers, summary reports to Practice Governance and clinical and care governance group and to System Leadership Group. Strategic direction provided by Senior Management Team. HSCM Response Group continues to meet and reviews the key performance information and actions that are required to deliver the priority services.
Gaps in assurance:	Development work in performance to establish clear links to describe the changes proposed by actions identified in the Strategic Plan has recommenced but is at an early stage. This will be progressed as the revised outcomes are determined and associated KPI are identified. Progress will be reported to future Board meetings. Review of systems and processes will commence across HSCM to ensure they are fit for purpose and ensure that there are no indirect consequences of structure changes resulting in any gaps in assurance processes.
Current performance:	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. The Unmet need report continues to show improvement in a number of Performance Indicators, with a number of them now showing continued improvement over the longer-term.
Comments:	Locality profile information has been provided to Locality Steering Group/Locality Manager to inform potential priorities for consideration in Localities and work will be taken forward regarding development of performance monitoring and

	reporting of key performance indicators in relation to Localities once it has been determined what the intended outcomes are. Locality plans will be presented to the IJB in March 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. This work is being undertaken across the Moray Portfolio to improve wider system flow. Progress in this area has been hampered due to the increased demand for urgent or critical services requiring staff resource to be prioritised to frontline service delivery. The Council has procured new modules for their performance reporting system Pentana and HSCM performance team have been developing its use for reporting.

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. A Moray Portfolio Infrastructure Programme Board has been established to support the operational delivery of the aims and objectives set e.g. Analogue to Digital changeover, Buildings and Assets oversight and Smarter Working will support this agenda.
Gaps in assurance:	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 will conclude December 2023. ICT infrastructure service plans in NHS Grampian and Moray Council are not yet visible to HSCM and development of communication and engagement process is required. 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. Internal Audit Services have indicated that their capacity to complete all work required by MIJB may be an issue. This is being discussed with Moray Council. Recruitment for vacancies takes considerable time due to various factors and is presenting a strain on services to maintain normal service whilst covering vacancies. There have been several posts that have had to go out to advert more than once extending the time other staff are covering gaps.
Current performance:	No update.
Comments:	Existing projects will be reviewed as part of the development of the transformation plans for the Strategic Plan to ensure resources are being dedicated appropriately and aligned to the emerging Strategic priorities. Our requirements for support will be communicated via appropriate channels

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 25 MAY 2023**

SUBJECT: **PRIMARY CARE MINOR SURGERY**

BY: **PRIMARY CARE DEVELOPMENT MANAGER**

1. REASON FOR REPORT

1.1. To inform the Clinical and Care Governance Committee of the current position regarding the Moray Primary Care Minor Surgery Service.

2. RECOMMENDATION

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

i) the current position of Primary Care Minor Surgery Service which is delivered from the Dr Grays site; and

ii) the impact on Moray patients.

3. BACKGROUND

3.1. The situation being faced by the service is due to the lack of access to the GP Referral Minor Operations facility at the Dr Grays site.

3.2. This has been the case now since October/ November 2022 when the service was asked to vacate the facility on a Thursday to allow Ophthalmology to use the space for essential procedures.

3.3. There are 3 GP Referral Surgeons but with a reduced capacity to undertake procedures. As a consequence the services waiting time has gone up significantly.

3.4. The ongoing nature of this problem has several important affects:

- reduced operating capacity;
- escalating waiting lists including for excisions of cancerous skin lesions referred via GP and Dermatology;
- negative affect on morale of staff;

- negative affect on future sustainability planning for the service (for example, the ability to take on another GP Career Start Referral surgeon and ensure future proofing succession planning and potential survival of the service).

3.5. It is important to stress that should this important service fail, this workload would not go back to General Practice but to secondary care.

3.6. Meantime waiting lists have increased along with complaints, which are being managed verbally at this time.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1. The Morayshire GP Referral Surgery Service was commissioned at Dr Gray's Hospital, Elgin in 2003 under the management of Primary Care and has the following key objectives:

- to provide a day case surgical service under Primary Care management to undertake surgical procedures not suitable to be undertaken in GP Practice and to relieve waiting list pressures in Secondary Care.
- to provide the opportunity for GP Referral Surgeons (GPwSI's) to skill up in surgical assessment and procedures and to offer training and support to other GP Minor Surgeon colleagues in a community setting.
- to offer basic training and support to medical students attached to surgical specialities at Dr Grays.
- to offer a training program for trainee GPwSI's through the GP Career Start Program.
- to work in a Managed Clinical Network with other hospital based specialties including General Surgery, Dermatology, Plastic Surgery, Orthopaedics.
- to work within accepted guidelines of surgical practice, undertake audit and service review as part of a wider Clinical Governance framework.

4.2. The service has developed over the years, now operating out of the Minor Surgical theatre facility on the Grays site every Wednesday, Thursday and alternate Fridays.

4.3. Historically, the service had another operating facility at Seafield Hospital, this was discontinued due to concerns regarding the standard of the operating facility itself (infection control, poor ventilation, lack of store room, non-compliance with Clinical Governance standards and the fact that the facility was situated in a designated non-clinical zone).

4.4. Referrals are accepted from Primary Care (GP Practices) and Secondary Care (dermatology, surgery, orthopaedics) and the key emphasis is to undertake a repertoire of procedures suitable for the facility and the skill set of the GP Referral Surgeons. In general terms, the service undertakes Level 3 procedures. These procedures include:

- excision of facial lesions not requiring skin grafting including Basal Cell Carcinoma (a type of skin cancer), excoriated skin lesions and benign lesions causing symptomatic problems. Suspicious pigmented (melanocytic) lesions should ideally be referred to the Dermatology

Multi-Disciplinary Team unless they are being referred directly from that service
- excision of larger sebaceous cysts, lipomas
- vasectomies (Non scalpel technique)
- carpal tunnel assessment, carpal tunnel release and steroid injections

4.5. Strengths:
- well organised, central, locally based service, well trained, motivated and functional team operating within a Managed Clinic Network.
- efficient and well audited service delivering good clinical outcomes to patients
- excellent facility at the Dr Grays site compliant with infection control. Support available from hospital based colleagues for any adverse clinical scenarios.
- high regard for the service from the local GP community and patient users alike.
- delivering training and support to medical students, trainee GP Referral Surgeons, hospital Surgical Specialty Trainee's and community based GP Minor Surgeons.
- relieving waiting list pressures from hospital based, Secondary Care services.
- operating pan-Grampian to relieve waiting list pressures on Community based surgery (e.g. vasectomy waiting list initiative).

Weaknesses/ Challenges:
- lack of understanding of the GP Referral Surgery Service provision in the wider Grampian Secondary Care community.
- variation in the GP Referral Surgery service across including lack of central co-ordination of waiting lists, skill set of individual GP Referral Surgeons, lack of standardisation of facilities.
- significant recent threats to the Operating facility at the Dr Grays site due to competing secondary care service requirements. By implication, a reduction of operating capacity will lead to bigger waiting lists and further workload pressures applied to Secondary Care, and ultimately a direct threat to the long term viability of the Moray based GP Referral Surgery service.
- age spectrum of existing GP Referral Surgeons and lack of succession planning to meet future service demands.
- reduction in operating capacity at the Dr Grays site leading to a reduction in training opportunities to trainee GP Referral Surgeons.

4.5 Table 1 below details the waiting list for the service as at 29 March 2023.

		Procedures waiting for					
As at	No of Patients	Vasectomy	Lesions (lumps, bumps, SCCs, BCCs etc)	Carpal Tunnel release	Carpal Tunnel assess	Waiting Time in weeks	
05/07/2022	137	73	60	4	0	19	
14/09/2022	201	110	82	15	0	19/20	
24/10/2022	242	135	83	6	18	appt from 2020	Grampian WL initiative Vasectomy patients referred from back to 2020
07/12/2022	279	173	80	0	23	appt from Sept 2021	82 Vasectomy referrals from Grampian WL inititative so far
10/02/2023	285	196	85	2	2	appt from Feb 2022	Not receiving Grampian WL Vasectomies at the moment but ARI are regularly assessing our WL times with other services across Grampian
29/03/2023	280	174	98	6	2	34	

4.6 Table 2 below shows the number of appointments that have been lost since the service has been unable to access the Dr Grays facility on a Thursday

Clinic Date	No. of Appointments	
15/09/2022	6	
22/09/2022	6	
29/09/2022	6	
06/10/2022	6	
13/10/2022	6	
20/10/2022	6	
27/10/2022	6	
03/11/2022	6	
10/11/2022	6	
17/11/2022	6	
24/11/2022	6	
01/12/2022	6	
08/12/2022	6	
15/12/2022	6	
22/12/2022	6	
29/12/2022	6	
05/01/2023	6	
12/01/2023	6	
19/01/2023	6	
26/01/2023	6	
02/02/2023	6	
09/02/2023	6	
16/02/2023	6	
23/02/2023	6	
02/03/2023	6	
09/03/2023	6	
16/03/2023	6	
23/03/2023	6	
30/03/2023	6	
	174	

5. SUMMARY OF IMPLICATIONS

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

The policy and approach set out in this report is consistent with the MIJB Strategic Plan.

(b) Policy and Legal

A number of policy and legal implications to be considered

(c) Financial implications

Financial implications regarding the refurbishment at Dr Grays and/or purchase of equipment

(d) Risk Implications and Mitigation

Risks and mitigating factors are outlined within the report

(e) Staffing Implications

There are implications on staffing provision and on staff health and wellbeing

(f) Property

Implications regarding Dr Grays premises or alternative provision

(g) Equalities/Socio Economic Impact

None arising directly from this report

(h) Climate Change and Biodiversity Impacts

None arising directly from this report

(i) Directions

None arising directly from this report

(j) Consultations

Robert Lockhart, Moray GP Clinical Lead
Malcolm Simmons, Moray GP Clinical Lead
Charles Hornsby, Moray GP Referral Surgery Clinical Lead
Sean Coady, Moray Head of Service

All comments have been incorporated into this report.

6. CONCLUSION

6.1 Clinical and Care Governance Committee are asked to note the content of this report.

Author of Report: Rosemary Reeve, Primary Care Development Manager
Background Papers: GP Referral Surgery Service

Ref:

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 25 MAY 2023**

SUBJECT: **COMPLAINTS REPORT FOR QUARTER 4, 2022/2023**

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

1. REASON FOR REPORT

1.1. To inform the Committee of complaints reported and closed during Quarter 4 (1 January 2023 – 31 March 2023).

2. RECOMMENDATION

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

3. BACKGROUND

3.1. Within 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 4 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.

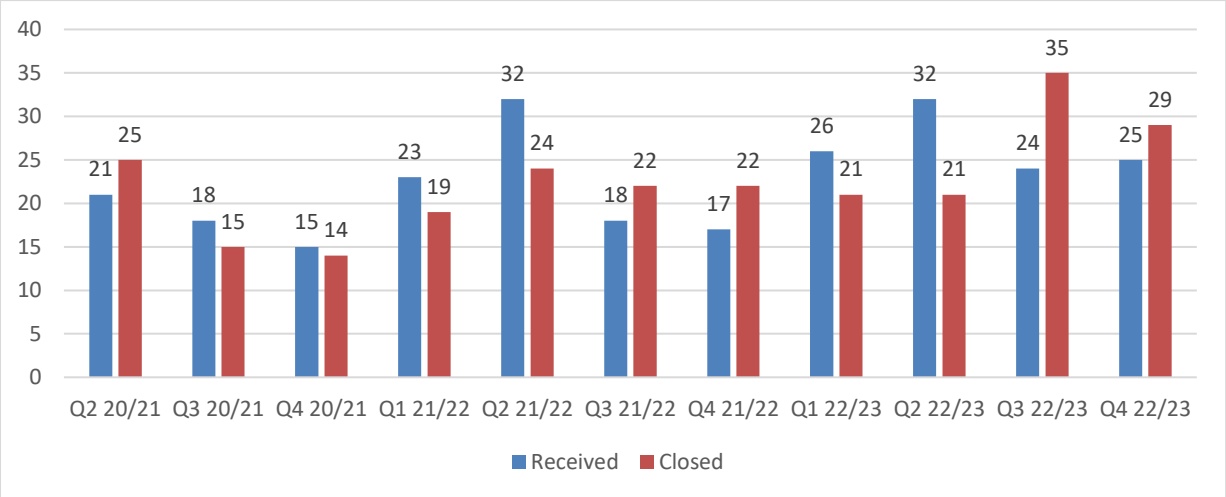
4.6. Overall, a total of 25 complaints were received during Quarter 4.

	Total Received Q1	Total Closed Q1	Total Received Q2	Total Closed Q2	Total Received Q3	Total Closed Q3	**Total Received Q4**	**Total Closed Q4**
LA	9	4	7	5	4	6	**9**	**8**
NHS	17	17	25	16	20	30	**16**	**21**
	26	**21**	**32**	**21**	**24**	**35**	**25**	**29**

4.7 HSCM aim to respond to all complaints within timescales but this is not always achievable due to the cross-service nature of some complaints and the level of investigation and coordination required. The average response times in working days for complaints recorded on the NHS system Datix (set out in Table 8 **Appendix 1**) is higher than expected due to a few complex complaints.

4.8 In one instance the complainant was unhappy with the initial response, so a meeting was then organised with actions agreed and complaint was only closed on the system when all actions were completed. In another case a complaint was received from 3 different sources at difference times, each complaint was investigated and responded to accordingly but recorded under the same Datix number on the system. Complainants are kept informed throughout whilst their complaint is open.

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



4.9. There were 8 MP/MSP enquiries received regarding council services, under HSCM, and recorded on the Council system, Lagan. These were allocated as follows:

Service	Number of Enquiries
Care at Home	2
Occupational Therapy	1
Access Team	4
Community Care Finance	1

4.10. 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.

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

4.12. One comment/suggestion and 2 concerns were received during Quarter 4 and recorded on Datix.

4.13. Following ministerial approval, Children and Families and Justice Social Work Services were formally delegated by the Local Authority to Moray Integration Joint Board on 16 March 2023. Future complaints reports will include complaints and enquiries received regarding these services.

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 4 (1 January – 31 March 2023). The governance and monitoring of complaints forms part of core business for teams and services and the provision of a good quality, effective and safe service is a key priority for all.

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

APPENDIX 1

Complaints Data (by closed complaints)

Quarter 4 (01/01/23 – 31/03/2023)

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 4, 2022/23

	Fully upheld: Complaint is accepted	Partially upheld: Complaint is partly accepted	Not upheld: Complaint is not accepted	Total
Access - Improvements made to service access	1	0	0	1
Action plan(s) created and instigated	0	1	0	1
Communication - Improvements in communication staff-staff or staff-patient	5	3	1	9
Education/training of staff	1	2	0	3
No action required	1	0	6	7
System - Changes to systems	2	0	0	2
Share lessons with staff/patient/public	3	1	0	4
Waiting - Review of waiting times	2	0	0	2
Total	15	7	7	29*

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

Table 2

Complaints Information Extracted from Lagan:

8 complaints were **closed** during Quarter 4, 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	1	2	0	0	3
		Care at Home	1	0	0	0	1
		Community Care Finance	1	0	0	0	1
		Learning Disability	0	1	0	0	1
		Moray West	0	1	0	0	1
		Occupational Therapy	0	0	1	0	1

Graph 1

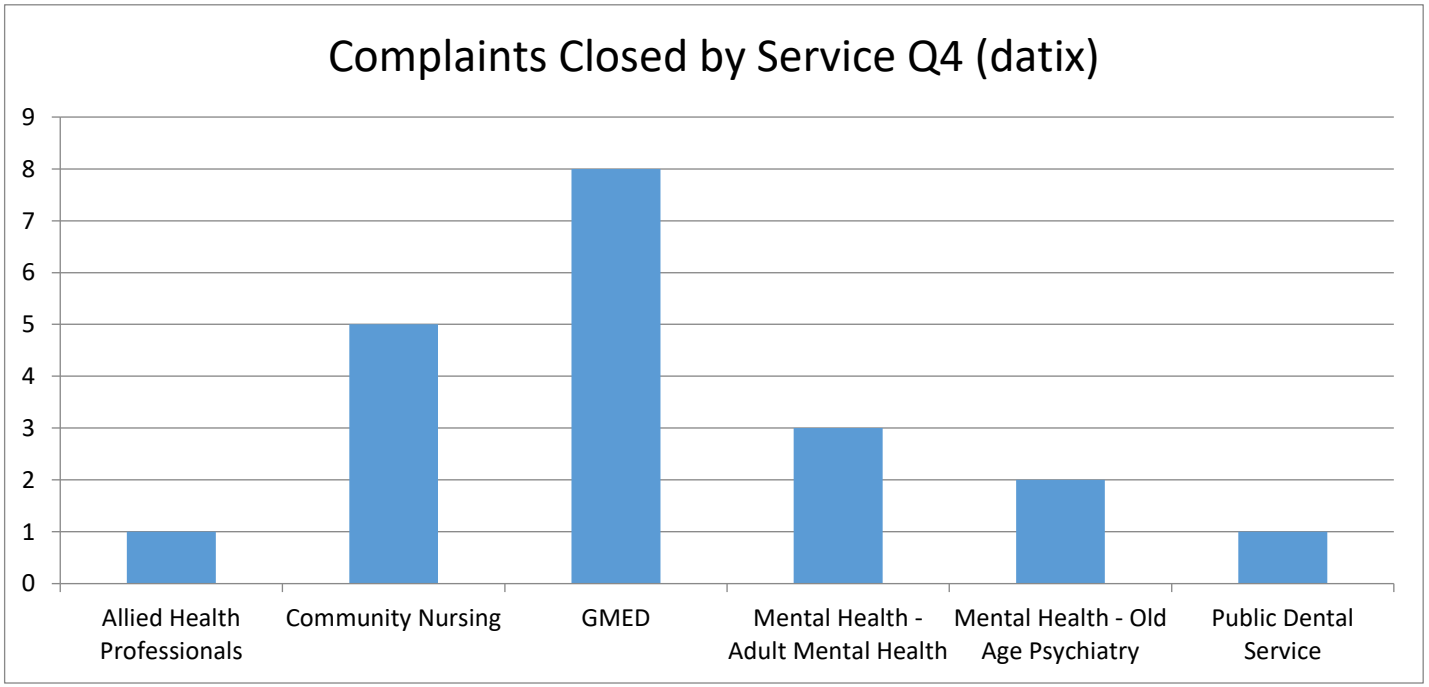


Table 3

Complaints Information Extracted from Datix – Action Taken by Service (complaints **closed** during Quarter 4, 2022/23)

	Allied Health Professionals	Community Nursing	GMED	Mental Health - Adult Mental Health	Mental Health - Old Age Psychiatry	Public Dental Service	Total
Access - Improvements made to service access	0	0	0	1	0	0	1
Action plan(s) created and instigated	1	0	0	0	0	0	1
Communication - Improvements in communication staff-staff or staff-patient	0	2	4	1	2	0	9
Education/training of staff	0	0	2	1	0	0	3
No action required	0	3	3	1	0	0	7
System - Changes to systems	0	1	0	0	1	0	2
Share lessons with staff/patient/public	0	0	2	0	1	1	4
Waiting - Review of waiting times	0	0	1	0	0	0	1
Total	1	6	12	4	4	1	28*

**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	Adjustment to therapy materials provided to patients
Communication	Staff reminded of importance of clear communication with patients at all times
	Staff reminded of importance of accurately extracting information
Education/Training	Training and awareness raising for security teams
	Staff reminded of the need for timely note keeping
	Training for staff and learning around documentation and trauma informed writing

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 4, 2022/23

System recorded	Early Resolution / Frontline	Investigation	Not Marked	**Total**
NHS - Datix	**4** marked early resolutions	**12** marked investigation	**0**	**16**
Moray Council - Lagan	**6** marked frontline	**2** marked investigative	**1** not yet marked	**9**
Total	**10**	**14**	**1**	**25**

Table 5 – Allocation of complaints **received** in Quarter 4, 2022/23

NHS Service - Datix	
GMED	5
Community Nursing	4
Adult Mental Health	5
Public Dental Services	1
AHP	1
Total	**16**

Table 6 – Allocation of complaints **received** in Quarter 4, 2022/23

MC Service - Lagan	
Care at Home	1
Access Team	4
Occupational Therapy	1
Moray West	1
Learning Disabilities	1
Community Care Finance	1
Total	**9**

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 **21 Complaints closed** on the NHS system Datix during Quarter 4, 2022/23 – breakdown as follows:

Early Resolution – 3

Investigation – 16

Ombudsman – 2

There were **8 Complaint closed** on the MC system Lagan during Quarter 4, 2022/23 – breakdown as follows:

Frontline – 6

Investigation – 2

No complaints were escalated

Table 7 – number and percentage of complaints at each stage closed within timescales **(based on complaints closed during Quarter 4, 2022/23)**

	Frontline/Early Resolution within timescale	Investigation within timescale
NHS - Datix	1 out of 3 (33%)	2 out of 16 (13%)
Moray Council - Lagan	3 out of 6 (50%)	0 out of 2 (0%)

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 4, 2022/23)**

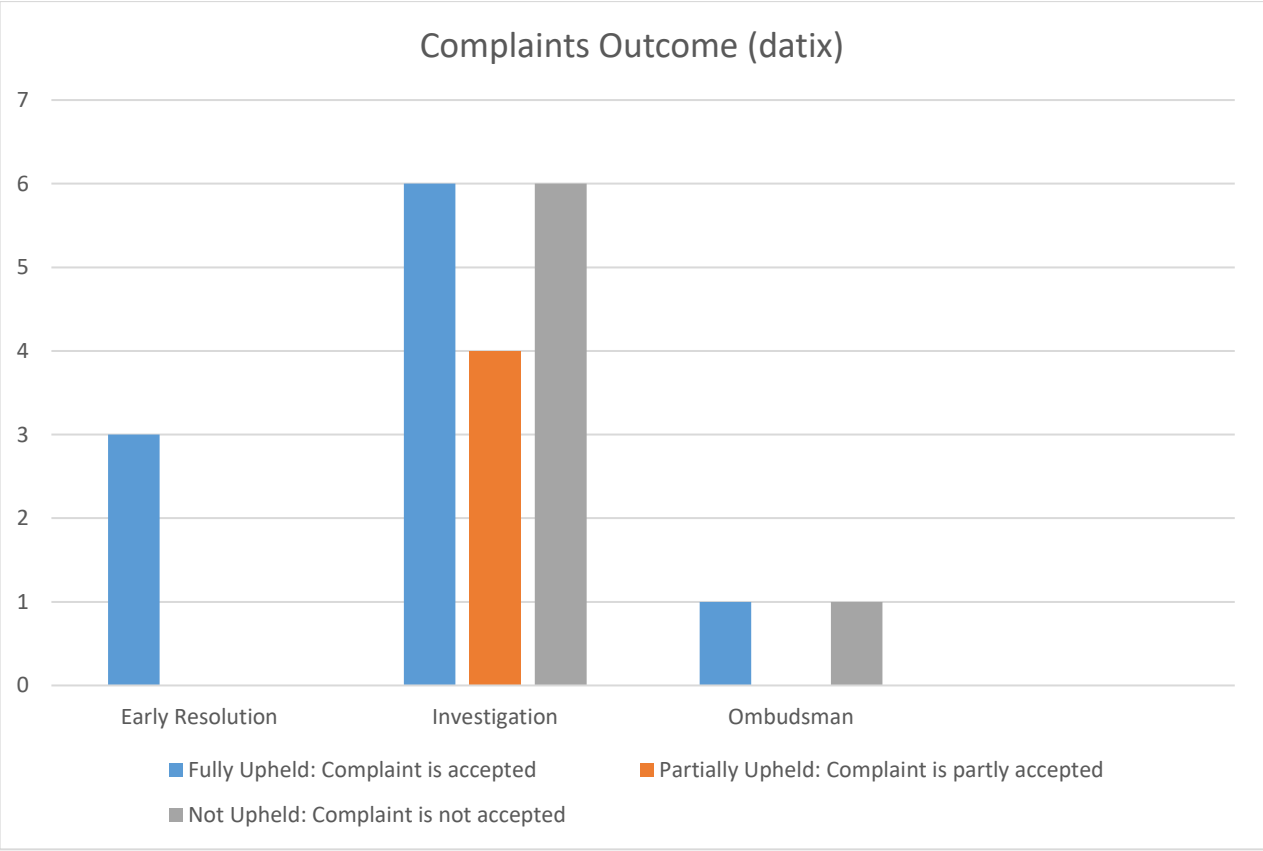
	Frontline	Investigative
NHS - Datix	4 days	69 days
Moray Council - Lagan	8 days	63 days

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 4, 2022/23.

From the 21 complaints closed during Quarter 4 - approximately 48% were upheld, 19% were partially upheld and 33% were not upheld

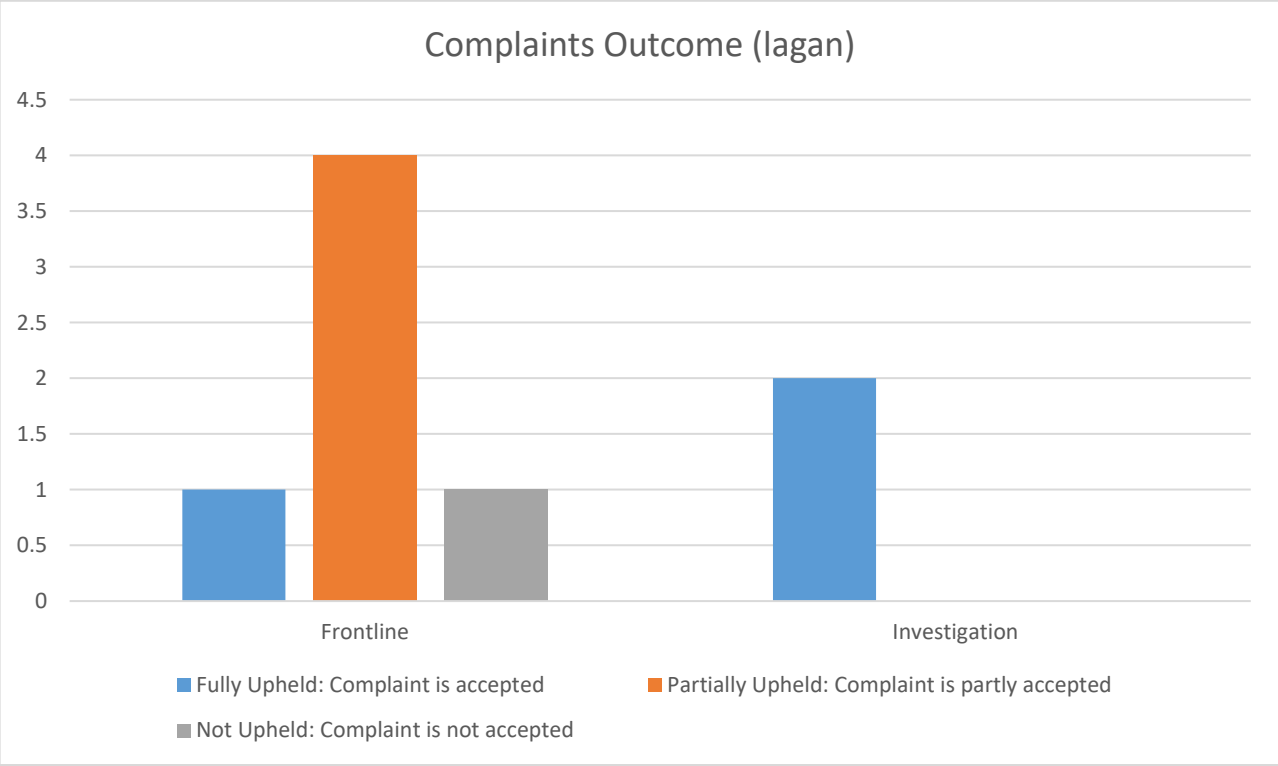


Complaints Information Extracted from Lagan:

8 complaints were **closed** during Quarter 4, 2022/23: **38% were fully upheld, 50% partially upheld and 12% were not upheld.**

0 complaints were escalated.

Graph 3 below shows the amount of complaints upheld, partially upheld and not upheld as recorded in Lagan from the **8 closed** complaints during Quarter 4, 2022/23.



REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 25 MAY 2023**

SUBJECT: **DUTY OF CANDOUR ANNUAL REPORT (2021/2022)**

BY: **CHIEF NURSE - MORAY**

1. REASON FOR REPORT

1.1 To submit for information the contents of Duty of Candour Report for Health and Social Care Moray for the year 2021/2022

2. RECOMMENDATION

2.1. It is recommended that the Committee consider and note the contents of this report and the attached Duty of Candour Annual Report (Appendix 1).

3. BACKGROUND

3.1 There is a statutory legal duty placed upon Health & Social Care Moray (HSCM) as a Health Care Provider to implement robust Duty of Candour processes. This is in order that patients who may be affected by unintended or unexpected incidents which may cause them harm may be involved in a meaningful way in a review of those incidents and to provide a framework whereby they may receive an apology.

3.2 The report provided for consideration here relates to an annual review of Duty of Candour processes and incidents which have taken place in the preceding year with a view to monitoring and continually improving these processes.

3.3 This report covers the period 1 April 2021 to 31 March 2022. The delay in submission is due to vacancies and secondments of key personnel following on from the Covid-19 pandemic. Details of Duty of Candour activity in HSCM was submitted to NHS Grampian in time for inclusion in the NHS Grampian Duty of Candour Annual Report.

3.4 The 2022/23 HSCM Duty of Candour Annual Report is currently being compiled and is on track for being finalised by 30 June 2023 and will be presented to the August Clinical and Care Governance Committee.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 During the Period 1 April 2021 to 31 March 2022 a total of 8 incidents were considered under Duty of Candour.

4.2 Of those 8 incidents Duty of Candour was applied in relation to 4, all of which were effectively closed. All 4 incidents were classified as Minor and were uncomplicated.

4.3 Of those 4 incidents remaining "queried", all were found to be more complex in nature and spanning multiple departments. This trend has been well noted and actions are underway to address this trend.

4.4 In order to improve the handling of more serious and complex potential Duty of Candour incidents a series of improvements are scheduled to take place over the first 6 months of 2023.

4.5 The following improvements are scheduled:

- The Clinical Risk Management (CRM) structure is under review, with a proposed improvement being that there will be a heightened focus on flagging and allocating Duty of Candour status to all queried incidents as they arise within the meeting. This allows the combined expertise of the team to be effectively utilised.

- There is a review of incident investigation processes underway within the HSCM with face to face training and workshops being made available. Key to these will be the further training and understanding of Duty of Candour and where it applies.

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

Duty of Candour (Scotland) Regulations, 2018, clearly state the requirements to engage with patients in a meaningful way should it be identified that unintended or unexpected incident's result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition. In each case, a review of what happened takes place and what went wrong to try and learn for the future.

(c) Financial implications

There are no financial implications arising as a direct result of this report.

(d) Risk Implications and Mitigation

The process is to ensure continued compliance with the relevant statutory requirements and continue to reduce risk by rapidly integrating learnings taken from effective and meaningful interactions with patients who may have been impacted whilst under the care of HSCM. Of significance is the reduction of reputational risk which can be achieved effectively in applying the Duty of Candour (Scotland) Regulations, 2018.

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

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

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

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

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

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

6. CONCLUSION

6.1 The committee are recommended to acknowledge the implementation and ongoing improvements put in place in order that the HSCM comply with its Statutory Duty under Duty of Candour (Scotland) Regulations, 2018 and that following the Covid-19 pandemic period learnings and improvements are being implemented rapidly and effectively in this regard.

Author of Report: Jacqui Shand, Interim Clinical Governance Co-ordinator (HSCM)
Background Papers: DOC annual Report April 2021 – March 2022
Ref:

APPENDIX 1

Duty of Candour Annual Report

1st April 2021 – 31st March 2022

Approved: Clinical and Care Governance Group
Date: December 2022

Lead : Samantha Thomas
Chief Nurse
Moray

Background

All health and social care services in Scotland have a Duty of Candour. This is a legal requirement which means that when unintended or unexpected events happen, that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this Duty is that an annual report is produced about how the duty of candour is implemented in services. This short report shows how Health and Social Care Moray has operated the Duty of Candour (DoC) during the time between 1st April 2021 and 31st March 2022.

About Health and Social Care Moray

Health and Social Care Moray (HSCM) is an integrated health and social care partnership working under the direction of the Moray Integration Joint Board (MIJB). Moray has a population of approximately 95,000 (ISD General Practice Populations data) and stretches across approximately 860 square miles of predominantly rural landscape.

Moray Integration Joint Board (MIJB) was established in February 2016 and became operational as of 1 April 2016. It has responsibility for the planning and delivery of all community based adult health, and social care services within Moray. In addition MIJB has strategic planning responsibilities in respect of emergency care and it also hosts those pan Grampian services relating to the out of hours, Grampian Medical Emergency Services (GMED) and Primary Care Contracts who are responsible for all contractual arrangements for the 4 Contracted Services (General Practice, Community Pharmacy, Optometrists and Dentists).

Most people live in the natural communities/main towns of Elgin, Lossiemouth, Buckie, Forres and Keith. Other smaller communities are also scattered throughout Moray e.g. Hopeman, Burghead, Cullen and Aberlour, Dufftown, Fochabers, and Tomintoul in remote and rural locations.

Three community hospitals exist in Moray in the towns of Buckie, Dufftown and Keith providing 51 inpatient beds in total delivering a range of acute and intermediate care services for local areas. Community health and social care services are built around the community hospitals with community based teams co-located where possible.

Adverse Events Reporting and Duty of Candour Process

HSCM identify DoC incidents through Datix – NHS Grampian's adverse event management process. Through the significant adverse event review process any factors that may have caused or contributed to the event are established, which helps to identify DoC incidents.

At present, consideration as to whether the Duty should be triggered is requested for all adverse events where a patient is the person affected, the event resulted in harm and the event was reported on or after 1st April 2019. In all instances where the

criteria are met it is mandatory to record whether the event triggers the Duty, the person who made the decision and the rationale for the decision. If it is decided that the Duty is not triggered, there are no further changes to the information required to be recorded on Datix. Where it is decided that the Duty has been triggered, additional sections and questions will appear on the form.

Once the Duty has been triggered, the next step is to identify the 'relevant person' i.e. the person that NHS Grampian will be communicating with regarding the event and the application of the Duty.

If it has not been possible to identify a relevant person, make initial contact with them or provide an account of the event and subsequent actions to expect, it will be recorded why that has not been possible.

Following the notification, a meeting should be arranged with the relevant person. There is no set timescale for when this meeting should occur by but, given that the relevant person's views and questions should inform the terms of reference for the review, it is expected that it will be as soon as is reasonably possible.

It is recommended that where the Duty has been triggered a minimum of a Level 2 review is carried out by the local management team, including a service manager with multidisciplinary team input. A Level 1 review where a significant adverse event analysis and review is required can also be initiated.

Following the review, a copy of the report should be offered to the relevant person and provided if requested. The relevant person should also be offered the opportunity for follow-up discussions after that time. Recommendations are made as part of the adverse event review, and local management teams develop improvement plans to meet these recommendations.

From 1 December 2020, all services are required to identify on Datix which of the relevant outcomes from legislation has occurred and caused the Duty to be triggered. This will be in addition to the information already collected. This assists in clarifying and confirming the decision to trigger the duty of candour and will help NHS Grampian fulfil its reporting requirements to the Scottish Government.

It is recognised that adverse events can be distressing for staff as well as people who receive care. Support is available for all staff through the line management structure as well as through the occupational health service.

Number and Nature of Duty of Candour Incidents in Health and Social Care Moray

To help to support the correct allocation of the Duty, all incidents that have caused harm have been reviewed for accuracy.

Between 1 April 2021 and 31 March 2022, **8** incidents were considered as DoC. At the time of writing, DoC has been confirmed and applied to **4** incidents. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or

underlying condition. In each case, a review of what happened takes place and what went wrong to try and learn for the future.

All of these incidents which were definitively classified as having Duty of Candour applied have been closed effectively. All incidents which were identified were Minor incidents with the data showing that the Pathway followed in relation to tissue viability being the most successful in effectively identifying Duty of Candour at an early stage and allowing effective preventative action and closing of the incident to be put in place. This indicates good practice which should be taken forward as a learning.

Of those incidents which have been ranked as "Query – requiring advice" in relation to Duty of Candour, they tend to be those which are more serious and complex in nature, with another common theme being that all 4 related to episodes of patient treatment which span multiple departments or disciplines.

This trend mirrors the general "silo working" between disciplines which may at times impact patient care.

Of these queried incidents 2 are still in the investigation phase, with one being a Level 1 Review, recently commenced. All Level 1 and Level 2 reviews are considered at the fortnightly Clinical Risk Management (CRM) Group to monitor progress and provide challenge. Going forward this group will review all "Query" DOC's as a defined agenda item and will seek to provide guidance to investigation teams at an earlier juncture to ensure DOC status is defined early in the investigation process.

It is clear from the data that in the case of minor incidents within their own department staff feel empowered and confident to assign DOC status and deal with the incident effectively.

In relation to more complex cases it takes longer to categorise incidents and this can lead to a delay in engaging patients and family members. Improved support for teams via the CRM meeting on a fortnightly basis and additional training workshops to improve overall Incident Investigation skills are anticipated to significantly improve staff confidence and competency in being able to identify Duty of Candour incidents more rapidly and deal with them more effectively.

Overview of 4 DoC from reviews completed:

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	1
Changes to the structure of the person's body	1
The shortening of the life expectancy of the person	
An impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	

The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.	1
The person required treatment by a registered health professional in order to prevent:	
The person dying	
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	1

Learning

All staff receive training on adverse event management and implementation of Duty of Candour as part of the NHS Grampian induction, this to ensure staff understand when it applies and how to trigger the Duty. Additional training and support is also available for those members of staff who frequently review adverse events, and for those who are regularly key points of contact with people who have been affected by an adverse event.

Adverse events, whether they trigger the Duty or not, are reviewed fortnightly at the local Clinical Risk Management (CRM) group, and exceptions are escalated through the HSCM Clinical and Care Governance Group. This forum also provides a platform for sharing learning and identifying challenges.

The fortnightly CRM will apply a more robust process going forward ensuring all 'unsure' DoC are discussed with the appropriate service manager and subsequently recorded appropriately on Datix. A contact will be provided for staff to discuss DoC legislation to assist in decision making. DoC training will be refreshed for all staff as matter of priority.

A sequence of specialist Risk Management and Incident Investigation workshops with an emphasis on Root cause analysis will be rolled out for staff, throughout the first quarter or 2023. The objective of this face to face training series is to significantly up-skill staff in terms of undertaking rapid and effective incident and complaint handling.

It is observed that when cases are more complex staff lack the confidence or feel they lack the authority in triggering Duty of Candour. The more rigorous support of more senior and specialist staff through the CRM process, should address this in conjunction with face to face training rather than on-line modules alone is expected to address this.

Summary

This is the fourth year of the DoC being in operation. Moving out of the challenges of the pandemic allows us freed time and resource to strengthen processes and competency to continually improve our approach to Duty of Candour events. A continuous programme of learning is required to ensure that new staff and post holders are confident of processes.

Going forward we anticipate continuing to move towards more proactive Risk Management to reduce the number of adverse events and complaints, overall.

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 25 MAY 2023**

SUBJECT: **HEALTH AND SOCIAL CARE MORAY (HSCM) CLINICAL AND CARE GOVERNANCE GROUP EXCEPTION REPORT FOR QUARTER 4 (JANUARY TO MARCH 2023)**

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

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 4 of 2022/23 (1 January up to 31 March 2023).

2. RECOMMENDATION

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

3. BACKGROUND

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

3.2. The assurance framework for clinical governance was further developed with the establishment of the Clinical Risk Management 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 met twice during this reporting period. There was no meeting in January of this year.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

Audit, Guidelines, Reviews and Reports

4.1 Relevant Audits, Guidelines Reviews and Reports are tabled and discussed. These include local and national information that is relevant to HSCM, for example, recommendations from Health Improvement Scotland (HIS) reports from other areas which require to be discussed and assurance given that services in Moray are aware of these and have processes in place to meet/ mitigate the report recommendations. Overview from Quarter 4 2022/23 is listed below:

- Clinical Risk Management (CRM) meeting minutes
- External Reports
- Service Updates
- Adverse Events and Duty of Candour
- HSCM Risk Register
- Complaints / Feedback
- Update from Practice Governance Group

Areas of achievement / Good Practice

Moray Integrated Drug and Alcohol Service

4.2 The current lack of accommodation for this team is impacting on the ability of the team to meet Medication Assisted Treatment (MAT) standards and in turn is putting pressure on staff. The team does not have sufficient accommodation to see and review patients and dispense medication safely. Financial support has been sought and identified and good progress is being made to resolve this issue. The team is formulating a plan for the deployment of these funds to create these improvements.

4.3 The team in Moray are taking part in the trial of the TrakCare waiting list module. TrakCare is the electronic information system used across NHS Grampian. This has had a positive impact so far. Of note there is significantly more accurate reporting of waiting times. This improved ability to manage workloads and prioritise patients and implement earlier interventions has the benefit of reducing risk taking behaviour in this group of patients.

Optometry Service

4.4 Issues arose in relation to the delivery of surgery for Optometry with the reconfiguration of theatre facilities at Dr Gray's Hospital. This had resulted in the halting of optometry surgical lists in Moray and the associated lengthening of waiting lists, particularly in relation to cataract surgery.

4.5 This situation has now been eased by the recent reallocation of space in theatres at Dr Grays which has resulted in ophthalmic surgery recommencing. A Consultant Ophthalmologist is now running two theatre lists per week undertaking cataract surgery. The Clinical and Care Governance Group

(CCGG) were assured that given these changes the situation relating to cataract surgery has improved.

Day of Care Survey

4.6 As part of the System Pressures "two-week challenge" as a Scottish Government Initiative, Health and Social Care Moray undertook the Day of Care Survey for all in-patients in Moray. As well as performing the Day of Care Survey, the team took the opportunity to carry out qualitative interviews with staff to understand from an operational perspective, the pressure teams are under and to understand barriers and possible solutions to the flow of patients through our systems in Moray and Grampian wide.

4.7 The Day of Care Survey is a National Tool which is usually completed once a year throughout Scotland. The tool can be used at any time by teams who feel it would be beneficial to know their in-patient profile. The tool pays particular attention to those who could be discharged but there is a delay in their journey. This allows understanding of issues preventing discharge and provides data to support change.

4.8 A senior team of auditors spent two days carrying out the Day of Care Survey and Qualitative Interviewing in both Moray Community Hospitals (25 January 2023) and Dr Gray's Hospital (26 January 2023).

4.9 At this time a draft report detailing the outcomes of the survey is being reviewed by the Senior Management Team and the outcomes and recommendations will be considered by the Systems Leadership Team.

Clinical Governance Update

4.10 Two large scale workshops have been successfully completed where the senior management team undertook a series of exercises to review and refresh the clinical governance structure.

4.11 Two further workshops are currently underway. These are conducted on a team by team basis and are training orientated in nature.

4.12 Significant progress has been made in the design and improvement of both CRM and CCGG meetings and changes are underway – the results of which will be reported at the next meeting.

4.13 Please refer to the separate report, related to Clinical Governance Workshops which is presented within this agenda.

Children and Families Team

4.14 Due to challenges resulting from high vacancies, Health Visiting continues to operate on a reduced pathway. However, plans are now in place to stagger a return to a full service. This has been accompanied by significant achievements in relation to a return of staff appraisals and the opening of multiple training opportunities for staff.

4.15 The School Nursing Service in Moray remains in a critical situation with a high number of trainees and poor staff retention. This is coupled with a high level of need and lack of school readiness underpinning the difficulties in providing a comprehensive service. This situation is compounded by a lack of accommodation and absence of adequate safe storage for records for this

service. To date the team has initiated National benchmarking relating to service structure and delivery.

4.16 A comprehensive review of the Children and Families service across Moray has taken place resulting in clear recommendations around succession planning, staffing levels and proposing organisational change to remedy these generational issues which have grown over time and are heavily impacting the work of this team.

4.17 Budgets have been reviewed and staff movements and increased hours have been successfully implemented within the existing Health Visiting budget. This indicates adequate resource is in place to institute the planned changes.

4.18 The Children's Service Plan in now nearing completion with the priority areas for Moray being: Poverty, Disability, keeping Children Safe, looked after and care experienced children, whole family support and mental health & wellbeing.

Elgin Locality Team

4.19 The Elgin Locality Team have had significant success in instituting the full remobilisation (post-covid) of The Oaks as a centre for people to receive specialist unscheduled day care in Moray.

4.20 Following a successful test of change and the appointment of a Clinical Band 7 nurse and two Band 5 nurses, a range of both group and 1:1 services have been developed in collaboration with the people attending.

4.21 Several consultants are providing clinics at The Oaks, addressing conditions such as Multiple Sclerosis (MS) and Parkinson's disease. Patients can access a range of services on their visits to the centre without the need to be "referred on."

4.22 The developing of The Oaks as a centre of excellence for those on a palliative care journey in Moray continues with an action plan for longer term progress being supported by the Clinical Lead for Palliative Care.

4.23 The ongoing development of multidisciplinary teams within GP practices continues. This is showing further enhanced outcomes for patients and improvements for staff who feel more supported by the improved immediate access to colleagues from other disciplines.

GMED

4.24 GMED has been successful in undertaking a significant number of Audits and Surveys over the last quarter to interrogate their systems, benchmark and improve the service. These have included: Efficacy of Referrals, Clinical Note Audit, Redirection Protocols, and Patient Surveys.

4.25 GMED are showing success in the ongoing programme of Continuing Medical Education sessions to ensure the clinical team continue to reliably implement National Clinical Standards and guidelines. These sessions are now being aligned to the fortnightly review and outcomes of adverse events experienced by the service. This ensures that patients receive evidence-based and consistent care.

4.26 The GMED team have identified issues around responding to Mental Health Calls. Historically only GP's can respond to such calls. This has at times created a "bottle neck" in response and disruption for the wider team. Recruiting for a Mental Health Nurse is currently underway in order to improve the skills mix of the team and address these issues.

Home First Data Sharing

4.27 There were challenges regarding the sharing of large volume information relating to those that use health and social care services, which had the potential to create delays and poorer outcomes for citizens.

4.28 Information Governance have confirmed the overarching Multi-disciplinary Team Data Protection Impact Assessment (MDT DPIA) can be used which allows data sharing within the multidisciplinary teams supporting Home First.

4.29 This creates a working environment for staff that ensures all information, both health and social care, is known and opportunities exist to ensure better outcomes for citizens.

Clinical Risk Management (CRM)

4.30 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.

4.31 The group is attended by members of the senior management team, clinical leads, Chief Nurse and relevant Service Managers. The purpose is to ensure that senior managers are assured of the standards of services and that where necessary investigations are carried out appropriately and learning opportunities identified following adverse events and complaints.

4.32 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.

4.33 The Interim Clinical Governance Coordinator coordinates Clinical Governance 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.

Complaints and Feedback

4.34 HSCM complaints information for Quarter 4, 2022/23 is included in a separate report on today's agenda.

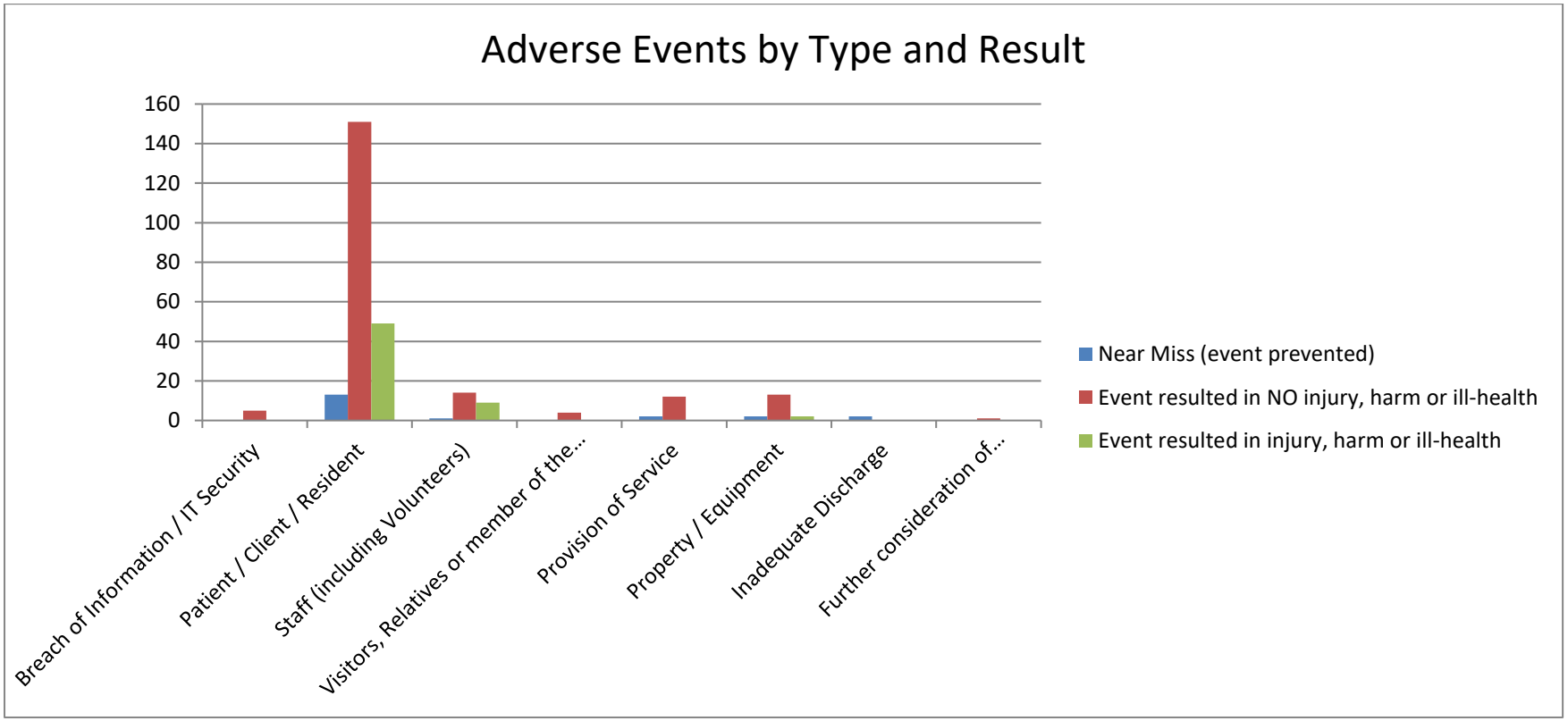
Adverse Events

4.35 Adverse Events by Category and Level of Review Reported on Datix (Quarter 4, 2022/23)

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	Level 1 - High Level Review	Total
Abusive, violent, disruptive or self-harming behaviour	57	0	0	57
Access, Appointment, Admission, Transfer, Discharge (Including Absconders)	12	0	0	12
Accident (Including Falls, Exposure to Blood/Body Fluids, Asbestos, Heat, Radiation, Needlesticks or other hazards)	99	2	0	101
Clinical Assessment (Investigations, Images and Lab Tests)	2	0	0	2
Consent, Confidentiality or Communication	9	0	0	9
Financial loss	5	0	0	5
Fire	10	0	0	10
Implementation of care or ongoing monitoring/review (inc. pressure ulcers)	15	1	0	16
Infrastructure or resources (Staffing, Facilities, Environment, Lifts)	5	0	0	5
Medical device/equipment	3	0	0	3
Medication	8	1	0	9
Other - please specify in description	31	1	0	32
Patient Information (Records, Documents, Test Results, Scans)	9	0	0	9
Security (no longer contains fire)	4	0	0	4
Treatment, Procedure (Incl. Operations or Blood Transfusions etc.)	5	0	0	5
No value	1	0	0	1
Total	275	5	0	280

Adverse Events

4.36 Adverse Events by Type and Result Reported on Datix (Quarter 4, 2022/23)



4.37 Adverse Events by Service and Level of Review Reported on Datix (Quarter 4, 2022/23)

	Level 3 - local review by line manager in discussion with staff	Level 2 - local management team review	Level 1 High Level Review	Total
Allied Health Professionals	9	0	0	9
Community Hospital Nursing	68	0	0	68
Community Nursing	28	1	0	29
Community Pharmacy	2	0	0	2
Community Therapy Services	2	0	0	2
General Practice	2	1	0	3
GMED	8	0	0	8
MacMillan Nursing Service	1	0	0	1
Mental Health - Adult Mental Health	73	0	0	73
Mental Health - Learning Disabilities	1	0	0	1
Mental Health - Old Age Psychiatry	60	2	0	62
Mental Health - Specialisms	7	1	0	8
Primary Care	3	0	0	3
Public Dental Service	8	0	0	8
Public Health	1	0	0	1
Administration	2	0	0	2
No value	0	0	0	0
Total	275	5	0	280

4.38 Adverse Events by Type and Severity Reported on Datix (Quarter 4, 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	Total
Breach of Information / IT Security	5	0	0	5
Patient / Client / Resident	169	37	6	212
Staff (including Volunteers)	16	9	0	25
Visitors, Relatives or member of the Public	5	0	0	5
Provision of Service	14	0	0	14
Property / Equipment	15	2	0	17
Inadequate Discharge	2	0	0	2
Total	226	48	6	280

4.39 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**	**2022.23 Quarter 4**
Occurrence with NO injury, harm or ill-health	193	239	271	189	218	214	283	200
Occurrence resulting in injury, harm or ill-health	80	61	87	79	89	98	78	60
Near Miss (occurrence prevented)	34	37	25	31	29	40	38	20
Property damage or loss	0	0	0	0	0	0	0	0
Death	0	0	1	0	0	0	0	0
Total	**307**	**337**	**383**	**299**	**336**	**352**	**349**	**280**

4.40 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**	**2022.23 Quarter 4**
Negligible	234	281	308	231	259	264	283	226
Minor	66	48	72	64	70	78	60	48
Moderate	6	8	2	2	4	8	5	6
Major	1	0	0	2	1	2	0	0
Extreme	0	0	1	0	2	0	1	0
Total	**307**	**337**	**383**	**299**	**336**	**352**	**349**	**280**

All adverse events have the appropriate level of investigation implemented.

Findings and Lessons Learned from incidents and reviews

4.41 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.

4.42 There are currently 3 Level 1 reviews in progress (at the time of reporting).

4.43 Key learnings from the last quarter as discussed at the CRM include the importance of competent leadership within incident investigation teams / panels to effect rapid closing and learning from incidents.

4.44 Second to that there is a significant intersect between HR processes and Incident Review Processes where incidents involve Human Factors such as competency and conduct.

HSCM Risk Register

4.45 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.

4.46 New risks identified on Datix are discussed at CRM. There has been 1 new risk reported during Quarter 4. This risk is ranked as Medium Risk and the risk is currently mitigated while a permanent solution is sought to eliminate the risk.

4.47 There is 1 “Very High” risk currently on the register. This is being closely monitored by the CRM and senior management team.

Duty of Candour

4.48 Two events were considered for Duty of Candour (DoC) during Quarter 4, Investigations have been completed. On investigation, one incident was found to not fit the criteria for DoC and the second did. All necessary communication has taken place and that incident has now been closed. The outcome of this review will be captured and included in future specific reports on DoC.

Items for escalation to the Clinical and Care Governance Committee

Community Learning Disability Team

4.49 It was previously reported to the group for escalation on the 4 August 2022, that there were significant difficulties in obtaining assessments for adults with incapacity, in keeping with the requirements of the Adults with Incapacity Act (Scotland), 2010.

4.50 These difficulties have arisen as a result of a lack of available Approved Medical Practitioners to undertake the assessments required under the law, to allow effective guardianship to commence. This bottleneck has created a backlog of such assessments leading to a failure to adequately support vulnerable individuals, at times stalling assistance and worsening circumstances for these vulnerable people for up to 6 months.

4.51 Consulting various partners has resulted in a temporary solution. This has a significant cost implication and is based largely on the good will of the clinicians involved, a situation which is precarious and not sustainable in the long term.

4.52 Although roles within Psychiatry are currently being recruited to, there still remains a deficit in staff who would be available to undertake such assessments. There is still currently no dedicated Consultant Psychiatrist working with the Community Learning Disability Team and no capacity assessment cover from the wider Learning Disability Service in Grampian. This situation is exacerbated by the fact that consultants cannot assess individuals who are currently not open to their service.

4.53 NHS Grampian Public Protection Committee has asked for a capacity pathway to be developed with regards assessment.

4.54 The development of such a pathway should drive rapid and effective assessment in accordance with the proscribed legislation and that this pathway encompasses all vulnerable people who may be effected by this Act.

Community Minor Surgery

4.55 Issues have emerged in relation to the delivery of minor surgery within the community as a result of the reorganisation of the Dr Gray's Hospital Theatres. A separate report is being presented providing detail on this, within this agenda.

Community Dental Team

4.56 The provision of the NHS Dental service remains under considerable pressure throughout Moray. This is primarily due to significant staff vacancies which are proving very difficult to recruit to. The Community Dental Team are currently covering basic levels of cover for emergency treatment for unregistered patients and have escalated these matters along with proposed actions to executive level within NHS Grampian.

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
- Fiona Robertson, Interim Chief Nurse Moray
- Tracy Stephen, Chief Social Work Officer
- Isla Whyte, Interim Support Manager

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 25 MAY 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 February 2023.

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: 15 May 2023

1The 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.
6 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 PRIORITIES**: 4, 5, 6	31-Mar-2024	08-03-2023 1 year direct award has not been offered. This was a Procurement and Senior Management decision. Commissioning will now be working towards a competitive tender Charles McKerron has been allocated operational lead officer.	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 PRIORITIES**: 4, 6	31-Mar-2023	Communication Plan written and in place with questionnaire to support discussion with supported people. Feedback to be provided at each APC via reporting.	100%		

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 PRIORITIES**: 1, 2, 3, 4, 5, 6	28-Feb-2024	Work ongoing	5%		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 PRIORITIES**: 2, 3, 4, 5, 6	30-Nov-2023	Quality Assurance Tool to be devised and cascaded with Team Manager involvement. Timetable of audit activity to be agreed	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 PRIORITIES**: 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 PRIORITIES**: 1,	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%		

		2, 3, 4, 5, 6					
ASP SIP Cat2.5	Audit of screening tool documentation (5 per month) to be undertaken and reported to APC	**Agency**: Local Authority	30-Nov-2022	Completed. Quality assurance in place for screening activities and feedback provided via Operational Working group and team discussions	100%		Vicki Low; Sammy Robertson
ASP SIP Cat2.7	Multi-Agency case conference table audit to take place – and learning to be disseminated	**Multi-Agency**	31-Jul-2023	Tool devised, audit to be undertaken **Assigned to**: Kenny O'Brien, Vicki Low	50%		
ASP SIP Cat2.8	Multi-Agency IRD Quality Assurance Audit to take place on a regular basis Multi-Agency Case Conference Assurance Audit to take place on a regular basis.	**Multi-Agency Care Inspectorate Priorities 1, 2, 3, 4, 5, 6**	31-Oct-2023	IRD Quality Assurance Tool written and has been implemented with Audits undertaken in 2022. To move to regular multi-agency activities Multi-Agency Case Conference Assurance Audit written – Audit to take place and regular activities moving forward	30%		

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 PRIORITIES:** 1,4	31-Mar-2023	ICT are progressing this. Acknowledgement that this may fall overdue	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	08-03-2023 – naming convention written and in place for ASP records.	100%		
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	**AGENCY:** Local Authority	31-Dec-2022	Audit required of CF system on a monthly basis – to take place March 2023.	100%		Vicki Low; Sammy Robertson

	activity on CF	**CARE INSPECTORATE PRIORITY**: 1, 2, 3, 4, 5,					
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	100%		
ASP SIP Cat3.7	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**	30-Jun-2023	Subgroup taking forward New National Data Set and ensuring Carefirst systems can accommodate changes moving forward. Data Set to commence April 2023. Acknowledgement that we may be unable to implement all requests – however, will work to rectify as we progress	20%		

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 PRIORITIES: 1, 2, 3, 4, 5	30-Jun-2023	Clear guidance in place for Team Managers in relation to chairing of Review Case Conferences and schedule now in place. To continue under review to ensure effectiveness To ensure regular communication with Team managers to ensure collaborative working	75%		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 PRIORITIES: 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 PRIORITIES: 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	**AGENCY:** Local Authority CARE	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	100%		Vicki Low; Sammy Robertson

	documentation on Carefirst. Attention required in relation to risk management and protection planning	INSPECTORATE PRIORITIES: 1, 3, 6		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			
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 PRIORITIES: 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%		Kenny O'Brien
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 PRIORITIES: 1, 5, 6	28-Feb-2023	Now fully in place - Champions running and live. Dates set.	100%		
ASP SIP Cat4.7	iVPD local process review to take place in order to identify opportunities for improvements in quality of information shared, and expectations of agencies receiving Adult Concern Reports from Police	**AGENCY:** Police CARE INSPECTORATE PRIORITIES: 1, 3, 5	30-Sep-2023	NHS pathway for Concern Reports completed and moving to Pilot phase in Aberdeenshire. Moray MIVA project launched and lead agency training undertaken with documentation of process cascaded. To continue to build on this for multi-agency use SLWG continues. More realistic end date set due to the scope of the project	50%		
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 PRIORITIES: 1, 2, 3, 4, 5, 6	31-May-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	100%		

ASP SIP Cat4.9	Develop and Implement a full Capacity Pathway for Protection Decisions	**AGENCY: NHS Grampian CARE INSPECTORATE PRIORITIES: 1, 2, 5, 6,**	31-Mar-2024	Membership agreed for SLWG. CSWO (or deputies) attending. GP Sub Committee has endorsed work and provided a member. Psychiatry and psychology also participating. First meeting in diaries for 10th May.	20%		

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 PRIORITIES: 1, 3	31-May-2023	Public Protection Training Calendar in progress – this will include training information for ASP, CP, VAWG, ADP – currently being drafted and then will be cascaded	95%		
ASP SIP Cat5.2	Collaboration with Social Work training to facilitate complex risk assessment across adult social work	**AGENCY**: Local Authority CARE INSPECTORATE PRIORITIES: 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 PRIORITIES: 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 Work	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITIES: 1, 3,	31-Dec-2023	08-03-2023 – Initial Lead Agency meeting to take place April 2023. This will also tie in with National Implementation Plan sub group work with IRISS	10%		Vicki Low; Sammy Robertson
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	**AGENCY:** Local Authority CARE INSPECTORATE	31-Aug-2024	Vicki devising Multi-Agency Training Report Template on a multi-agency basis. Expectation that first APC reporting will take place on a Multi-	10%		

	Council Officer refresher training is required	PRIORITIES: 1, 5, 6		Agency basis by May 23			
ASP SIP Cat5.6	Council Officer Handbook detailing tasks in relation to Adult Support and Protection duties and role	**AGENCY:** Local Authority CARE INSPECTORATE PRIORITIES: 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 PRIORITIES: 1, 2, 3, 4,	31-Jul-2023	Hoarding and Self-Neglect Training now available and disseminated to teams to book. Accompanying written guidance and information to be cascaded. – on track for July deadline.	90%		
ASP SIP Cat5.8	Developing a trauma informed workforce factoring in ongoing discussion with council officers to monitor changes in practice and to take forward learning	**Agency:** Local Authority CARE INSPECTORATE **PRIORITIES**: 1, 2, 3, 4, 5	31-Jan-2024	Trauma informed awareness session within council officer forum undertaken in Aug 2022. Trauma informed portfolio to be taken forward by BS (requires top-down approach). Discussion to take place within practice governance and a social work sub-group to be formed across adult and child services to take forward. Update – Job description to be written and presented to Senior Leaders for Project Officer to take forward Trauma informed work. **Assigned to**: Bridget Stone, Vicki Low, Emma Johnstone	50%		
ASP SIP Cat5.9	Develop a way to analyse training activities to inform the impact of training on practitioners This includes analysis exercise – training feedback used to inform future training events.	**Agency:** Local Authority CARE INSPECTORATE PRIORITIES: 1, 2, 3, 4, 5	31-Mar-2024	Ongoing. Feedback questionnaires are available following each training for participants. These are read and improvements notes. Council Officer standing survey introduced March 2023 to support learning and development and to highlight areas of improvements. Themes to be incorporated into Training Feedback to APC see action 5.16 **Assigned to**: Suzy Gentle	40%		
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 PRIORITIES: 1, 2,	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.	100%		

		3, 4, 5		**Assigned to**: Kenny O'Brien			
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 PRIORITIES: 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 PRIORITIES: 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 PRIORITIES: 1, 2, 3, 4, 5, 6	30-Nov-2022	Compliance rate requested - this can then be reviewed on a regular basis. Further review and assurance action to be documented below	100%		
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 PRIORITIES: 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%		
ASP SIP Cat5.16	Grampian Approach to Risk Assessment Training	**MutliAgency Care Inspectorate Priorities 1, 2, 3,**	30-Jun-2023	SLWG formed to take forward on a Grampian Basis. Training Slides drafted and finalising case study to be discussed as part of the training workshop	40%		
ASP SIP Cat5.17	Training update template to be drafted and completed prior to each APC to provide assurance of what training is taking place, how many participants. This should include	**MUTLI-AGENCY Care Inspectorate Priorities TBC**	30-Jun-2023	Template to be used for June APC. Once template has been used this will be completed and updates to be provided to APC on a regular basis.	90%		

	feedback information to allow for further learning and development						
ASP SIP Cat5.18	Consideration and exploration on a Grampian and multi-agency basis of an Adult Support and Protection Decisions App supported by the DHI.	**MULTI-AGENCY CARE INSPECTORATE PRIORITIES TBC**	31-Jul-2023	08-03-2023 – To date there has been initial discussion with all agencies and agreement that a Grampian wide decisions tool (if agreed) would be the most beneficial. Further discussion to take place on a Grampian basis via the Grampian Group	5%		

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 PRIORITIES: 5, 6,	31-Oct-2022	Initial discussions have taken place with Team Managers with regard to important of improvement and development for Social Work. Consultation Workshops planned for end Sep 2022. **Assigned to**: Vicki Low	100%		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 PRIORITIES: 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 PRIORITIES: 5, 6	30-Nov-2023	Theme – Grampian Procedures.	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 PRIORITIES: 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	30-Nov-2022	Council Officer Forums in place. Formally recorded and training materials to be available	100%		

		INSPECTORATE PRIORITIES: 1, 2, 3, 4, 5, 6		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			
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 PRIORITIES: 5, 6	30-Nov-2022	08-03-2023 – Fortnightly operational group meetings taking place with team manager and advanced practitioner attendance. This also has representation from Police, Carefirst Systems and NHS this group is an opportunity to share concerns or highlight areas of good practice.	100%		Vicki Low; Sammy Robertson
ASP SIP Cat7.3	To provide ongoing mentoring and support for Social Work Council Officers undertaking ASP activity	**Agency:** Local Authority CARE INSPECTORATE PRIORITIES: 1, 2, 3, 4,	31-Dec-2022	Training delivered to Council Officers OCT – DEC. Additional refresher training in March 2022. Rolling programme established. Ongoing mentorship of Council Officers taking place with tasking documents in place. **Assigned to**: Elaine MacDonald	100%		
ASP SIP Cat7.4	Review across all patient facing areas that professional supervision is offered/available	**AGENCY:** NHS Grampian CARE INSPECTORATE PRIORITIES 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%		
ASP SIP Cat7.5	Review local practice to ensure key agency professionals feel comfortable & have contacts for early discussion around ASP, promoting inter-agency peer support (This does not replace the IRD process, but a platform for time critical discussions.)	**MULTI AGENCY CARE INSPECTION PRIORITY 1, 5**	31-Dec-2022	completed - multi-agency contacts shared with front line practitioners to encourage good quality discussion and support during enquiry stage	100%		

REPORT TO: **MORAY INTEGRATION JOINT BOARD CLINICAL AND CARE GOVERNANCE COMMITTEE ON 25 MAY 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 committee of the progress relating to the refresh of the clinical and care governance structure within Health and Social Care Moray.

2. RECOMMENDATION

2.1 It is recommended that the Committee considers and notes the content of this report and the associated outcomes and recommendations therein.

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 outcomes from Workshop 1, held on 19 January 2023, were presented to the Committee at their meeting in February 2023. A follow up workshop, Workshop 2, was held on 24 February 2023.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The first two workshops (Workshop 1 and Workshop 2) allowed the Senior Leadership team to work together to identify issues, review structures, facilitate improved communications and create a plan to facilitate improvements.

4.2 A further two workshops were scheduled to facilitate learning in two key areas: Proactive Risk Management and Enhanced Incident Investigation Skills. The first of these workshops took place on 17 March 2023.

4.3 Currently three out of the four workshops have been successfully completed to date.

4.4 A series of changes as a result of the workshops are now being implemented, namely:

- A process of clearing longstanding and complex adverse event and complaints from the agenda of the Clinical Risk Management Meeting (CRM).
- Implementation of an improved format within the Clinical Risk Management Meeting to create greater visibility and peer support from within the group i.e. rapid and effective investigation of non-conformances and implementation and sharing of improvements.
- Improved sharing of best practice and peer support in both the Clinical Risk Management Meeting and the Clinical and Care Governance Meeting.
- Development of new tools, formats and timetables for Clinical Risk Management Meeting and the Clinical and Care Governance Meeting.
- Improved cross organisation working between the Local Authority and NHS components of the partnership.
- The teams who have participated in the educational workshops have identified credible progress is being made in terms of action planning and proactively addressing their most significant risks.

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 because there are no changes to policy as a result of this report.

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

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

(j) Consultations
Consultations have taken place with Head of Clinical Governance, Corporate Manager and Tracey Sutherland, Committee Services Officer, Moray Council.

6. CONCLUSION

6.1 The committee are asked to acknowledge the implementation and ongoing improvements put in place in order that the HSCM comply with its statutory duty to provide safe, cost effective and high quality health and social care services for the people of Moray.

Author of Report: Jacqui Shand, Interim Clinical and Care Governance co-ordinator (Moray HSCP)
Background Papers:
Ref: